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Evaluation of Michigan's Performance-Based Funding Model

Final Report

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Executive Summary

E1. Introduction

The Michigan Legislature, through Public Act 59 of 2013, Section 503, convened a task force that recommended a pilot project to plan, implement, and evaluate a performance-based funding model (referred to in this report as the Kent Model). The Kent Model is being implemented by the West Michigan Partnership for Children (WMPC), an organization that partners with five private Kent County-based service agencies.

The evaluation contract was awarded to Westat and its partners in 2016 and includes cost (Chapin Hall), outcome (University of Michigan School of Social Work), and process (Westat) components. The rigorous 5-year evaluation of the pilot was designed to test the effectiveness of the Kent Model on child and family outcomes in Kent County, results from which are summarized in this report. The cost study addresses cost effectiveness in service delivery, the outcome study documents changes in child and family outcomes (i.e., safety, permanency, and well-being), and the process study provides the context for foster care service implementation. While the comparison group for the cost and outcomes studies are all counties in Michigan other than Kent County, Ingham and Oakland counties served as the comparison counties for the process study.

E2. Methodology

The **cost study** is designed to understand the fiscal effects of the transition to the Kent Model using primarily system-level and child-level fiscal and placement data from Kent County. The cost study addresses the following research questions:

- What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?
- How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?
- To what extent does the WMPC case rate (and subsequent capitated rate) fully cover the cost of services required under the contract?
- What are the cost implications of the outcomes observed under the transition to the Kent Model?

To address the first two research questions, the cost study team examined system-level expenditure and revenue trends in Kent County and the rest of the state, focusing on the 3-year baseline period (FY 2015 – FY 2017) and the first 5 years post-implementation (FY 2018 – FY 2022). These expenditure patterns and revenue sources were also compared with those across the state, to address the second research question. The cost study compares total expenditures, care day utilization by placement type, and per diem costs of care in Kent County and the rest of the state.

For the third research question, to understand whether the case rate funding model used for the first 3 years of the pilot covered the cost of services, the cost study team analyzed expenditures and fiscal policy changes initiated by WMPC. The pilot switched to a capitated allocation model beginning in FY 2021, and the cost study team used care day utilization and the average daily cost of care to project spending on a quarterly basis. To answer the fourth question about the cost implications of child outcomes, the cost study team used child-level fiscal data linked to child placement spells (a period during which a child is continuously in out-of-home care) to compare the cost per outcome of children in Kent County to a matched comparison group. The study team examined the type, amounts, and costs of services received by children in out-of-home placements and compared them with those provided to a matched cohort of children receiving out-of-home services delivered by private providers across the state; the outcome study team developed the comparison group using propensity score matching (PSM).

The **outcome study** team used PSM to generate a comparison group, for children who entered care prior to the 10/01/2017 pilot implementation date and matches for children entering care after 10/01/2017, separately for each entry year. The comparison group is comprised of children who were in foster care at least 80 percent of the time and had statistically similar covariate representation (e.g., age, sex, removal year, allegation type, race, and ethnicity). The outcome study addresses the following research questions:

- Does the Kent Model improve the safety of children?
- Does the Kent Model improve permanency for children?
- Does the Kent Model improve the well-being (placement stability) of children and families?

Outcome results are reported for children in Kent County and the comparison group before and after pilot implementation. Differences between children in Kent County and the comparison group by entry year are reported when substantial differences were found among entry year results.

Over the course of the evaluation, the **process study** team conducted interviews and focus groups with public and private child welfare agency leadership and samples of supervisors and caseworkers; and representatives from the Michigan Department of Health & Human Services (MDHHS), county court systems, and mental health agencies; and WMPC to answer the following research questions:

- Do the counties adhere to the state's guiding principles in performing child welfare practice?
- Do child placing agencies adhere to the MiTEAM practice model when providing child welfare services?
  - What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services?
  - What factors facilitate and inhibit effective implementation of child welfare practice, in general, and, importantly, in the Kent Model (in Kent County)?
  - What resources are necessary to support the successful implementation of the Kent Model (in Kent County)?

The number of respondents each year ranged from 46 to 196 (n=124 in Year 1, n=196 in Year 2, n=98 in Year 3, n=156 in Year 4, n=153 in Year 5, and n=46 in Year 6). In Years 1, 2, 4, and 5 of the evaluation, the study team conducted interviews and focus groups with stakeholders in Kent, Ingham, and Oakland counties (and with MDHHS leaders in Years 1, 2, and 5). In evaluation Years 3 and 6, the study team collected data in Kent County only (and with MDHHS leaders in Year 6) to conduct an in-depth examination of changes resulting from Kent Model implementation. In evaluation years 1-6, focus groups and interviews included questions about Kent Model implementation, case planning and practice, services to families, monitoring and accountability, interagency collaboration, and challenges and facilitators. Data collection in the final year of the evaluation focused on implementation successes, limitations, and lessons learned.

E3. Cost, Outcome, and Process Results

Cost Study

Fiscal Trends Before and During the Pilot

Research Question: What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?

Overall, total out-of-home private agency expenditures increased in Kent County from FY 2016 through FY 2019 and decreased in FYs 2020 through 2022 (Table ES-1). In the baseline period prior to the pilot, from FY 2015 to FY 2017, total private agency expenditures (excluding URM, YAVFC, JJ, and OTI) increased by 12 percent, with the largest annual increase during the baseline period occurring from FY 2016 to FY 2017 when total expenditures increased by $3 million in the year immediately preceding implementation of the Kent Model (a 12% increase). Another large growth in private agency expenditures (20%) occurred from FY 2017 to FY 2018—the first year of the post-implementation period. However, in FY 2019 there was a slight expenditure increase, with a 5 percent escalation of private agency expenditures from FY 2018 to FY 2019. There was an annual decrease of 18 percent in total child welfare expenditures in FY 2020, followed by a 24 percent decrease in FY 2021 and a 17 percent decrease in FY 2022.

Table ES-1. Kent County[1] – Expenditures in thousands of dollars, by Fiscal Year, service domain, and URM/YAVFC/JJ/OTI status, adjusted for inflation

Service domain	Pre-implementation			Post-implementation				
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Total Kent County expenditures	$35,655	$38,187	$44,202	$51,219	$51,626	$45,572	$36,201	$29,015
Total private agency expenditures (excluding URM, YAVFC, JJ, & OTI)	$27,267	$27,104	$30,481	$36,515	$38,196	$31,219	$23,642	$19,528
Placement – Maintenance[2]	$12,832	$13,867	$16,498	$17,632	$17,691	$16,511	$12,107	$9,148
Placement – Administrative[3]	$13,214	$12,198	$13,481	$17,969	$19,843	$13,819	$11,059	$9,604
FC Placement Service	$934	$837	$216	$213	$245	$258	$273	$182
Residential Services	$112	$47	$134	$545	$259	$533	$99	$48
Mental Health	$139	$138	$122	$139	$124	$44	$31	$25
Physical Health	$8	$15	$20	$9	$15	$9	$6	$7
Independent Living	$0	$1	$1	$4	$13	$34	$65	$46
Education	$13	$1	$10	$4	$7	$12	$1	$2
Adult FC Service	$15	$0	$0	$0	$0	$0	$0	$466[4]
URM, YAVFC, JJ, or OTI expenditures	$8,388	$11,082	$13,721	$14,704	$13,430	$14,352	$12,559	$9,487

Note: FC = foster care.

The two largest funding sources for out-of-home placement services in Kent County are the Federal Title IV-E funds and the County Child Care Fund (Figure ES-1). Total Title IV-E revenue used each year remained fairly constant until an increase in FY 2018. The proportion of revenue attributable to this funding category declined in the baseline period—from 43 percent in FY 2015 to 36 percent in FY 2017. In FY 2018, Title IV-E revenue increased to make up 39 percent of total revenue, but between FY 2019 and FY 2022, this revenue source decreased in amount and proportion. During this same period, the amounts of all other funding sources fluctuated, but they each increased as a *proportion* of Kent County revenue.

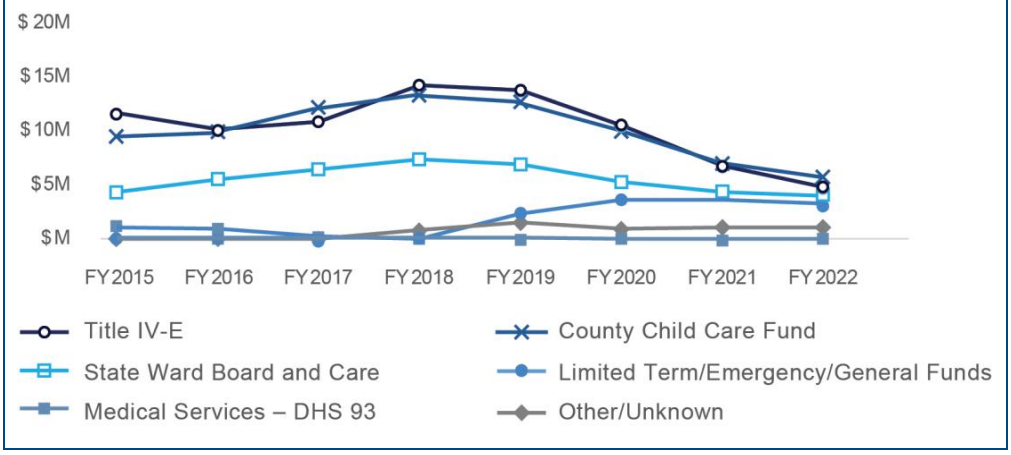
1 Kent County expenditures here represent all expenditures for which Kent County is listed as the responsible county.

2 Maintenance expenditures reflect the payments for the daily care and supervision of children in out-of-home care. For CCI placements, maintenance costs also include the provision of social services and clinical treatment. Administration expenditures represent the costs to manage child placement services and administrative costs related to foster care for children.

3 Administrative expenses reported are related to private agency payments, and do not include WMPC's $2 million administrative allocation.

4 During FY 2022, adult foster care services were added in Kent County.

Figure ES-1. WMPC-related – Revenue totals by overall funding source and Fiscal Year, adjusted for inflation[5,6,7]



Care Day Utilization

Expenditures are based on the number of care days provided, and the daily unit costs of care. As shown in Table ES-2, care-day utilization increased slightly in FY 2018 and again in FY 2019, compared to the 3 years prior to WMPC implementation. Care days decreased between FY 2019 and FY 2020 and continued to decline substantially in FYs 2021 and 2022. In FY 2022, care days declined 19 percent from 2021 levels, from 224,513 total days to 182,698 days.

Table ES-2. Kent County care days by state Fiscal Year and living arrangement (excluding URM, YAVFC, JJ, and OTI)

Placement setting	Pre-implementation			Post-implementation				
	2015	2016	2017	2018	2019	2020	2021	2022
Total Care Days	332,699	297,810	296,297	305,400	312,068	278,276	224,513	182,698
Foster Care	178,408	146,958	139,131	140,803	135,854	118,816	83,725	63,814
Kinship	71,401	78,331	82,039	88,166	98,987	83,569	75,396	70,475
Parental Home	38,986	29,667	28,989	26,649	27,967	28,586	26,237	15,163
Congregate	22,169	26,949	31,208	32,741	26,775	24,879	15,784	9,856
Independent Living	6,271	5,041	3,386	4,359	5,260	5,457	5,274	5,063
Emergency Shelter	1,688	1,861	3,311	3,109	2,829	1,957	635	300
Runaway	2,390	3,114	3,605	2,808	2,449	2,117	1,597	1,052
Enhanced FC				2,366	9,192	11,127	12,289	13,705

5 All pre-implementation revenue is determined by the OVERALL_FUND_SOURCE in MiSACWIS.

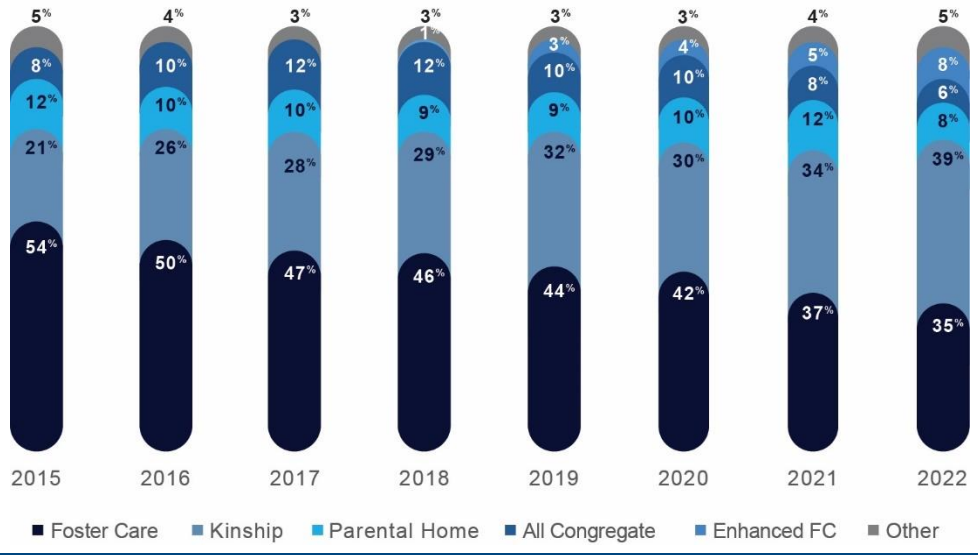
6 Most revenue in the post-implementation period is determined by the OVERALL_FUND_SOURCE in MiSACWIS or the revenue detail on the Residential Services tab in the WMPC Cost Report for the CCI placement expenditures. However, revenue associated with the aggregate EFC Admin costs was not available and was instead estimated by assigning revenue types to the EFC Admin expense based on the revenue type split in the pre-implementation period.

7 Other/Unknown revenue includes Temporary Assistance for Needy Families and Youth in Transition revenue and the revenue associated with Kids First expenditures.

Table ES-2. Kent County care days by state Fiscal Year and living arrangement (excluding URM, YAVFC, JJ, and OTI) (continued)								
Placement setting	Pre-implementation			Post-implementation				
	2015	2016	2017	2018	2019	2020	2021	2022
Adoptive Home	6,738	2,578	936	1,547	1,058	50	279	395
Detention	1,812	1,246	642	1,156	595	682	1,334	836
Treatment FC	2,142	1,524	1,677	923			46	
Hospital	694	541	1,373	773	1,102	1,036	1,917	2,039
Total Year-Over-Year Change		-10%	-1%	3%	2%	-11%	-19%	-19%
Foster Care		-18%	-5%	1%	-4%	-13%	-30%	-24%
Kinship		10%	5%	7%	12%	-16%	-10%	-7%
Parental Home		-24%	-2%	-8%	5%	2%	-8%	-42%
Congregate		22%	16%	5%	-18%	-7%	-37%	-38%
Independent Living		-20%	-33%	29%	21%	4%	-3%	-4%
Emergency Shelter		10%	78%	-6%	-9%	-31%	-68%	-53%
Runaway		30%	16%	-22%	-13%	-14%	-25%	-34%
Enhanced FC					289%	21%	10%	12%
Adoptive Home		-62%	-64%	65%	-32%	-95%	458%	42%
Detention		-31%	-48%	80%	-49%	15%	96%	-37%
Treatment FC		-29%	10%	-45%				
Hospital		-22%	154%	-44%	43%	-6%	85%	6%

Care day utilization by placement type has also shifted during the pilot. In the pre-pilot period (FYs 2015-2017), approximately half of care days were spent in foster care, 10 percent in congregate care, and one quarter in kinship care (see Figure ES-2). Since the pilot began in 2018, the proportion of care days spent in kinship care has gradually been increasing while foster care has decreased. This change may be attributable to WMPC's policy decision to implement paid kinship care. The proportion of days spent in congregate care remained at pre-pilot levels the first 3 years under WMPC (FYs 2018-2020) but has declined in the most recent 2 years (FYs 2021-2022). In FY 2018, 12 percent of care days were spent in congregate settings compared to 6 percent in FY 2022. At the same time, the proportion of days spent in WMPC's enhanced foster care (EFC) program, which is intended to reduce reliance on congregate care, has increased steadily from 1 percent of care days in FY 2018 to 8 percent in FY 2022.

Figure ES-2. Kent County care-day utilization by state Fiscal Year and placement setting as a percentage of total care days

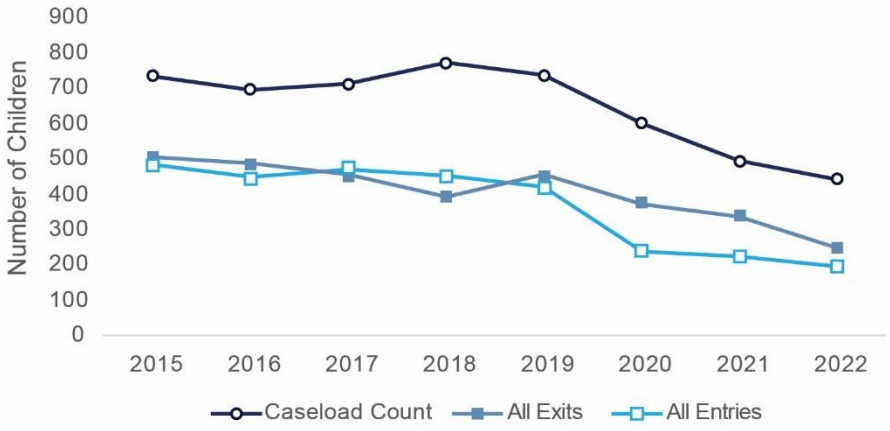


"All Congregate" includes congregate care, emergency shelter, and detention. "Other" placement settings include hospital, out-of-state placement, and runaway service facility.

Child Placement and Length of Stay Trends

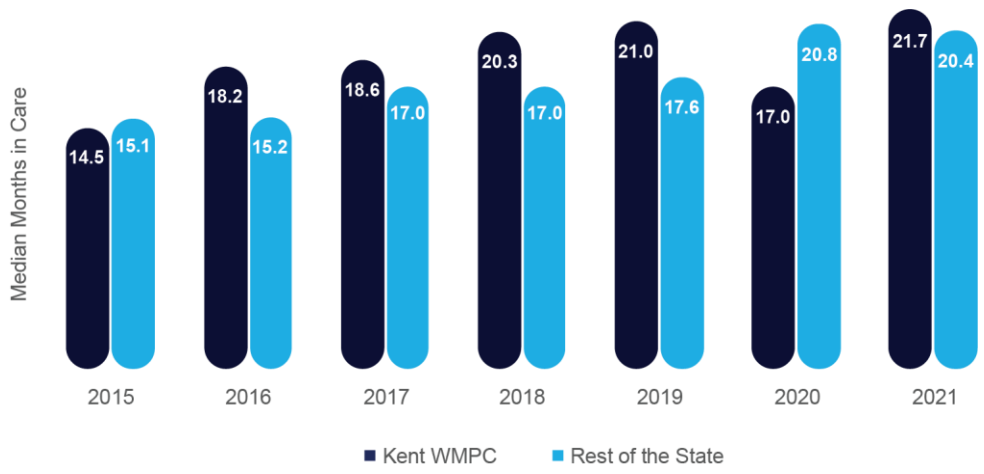
The decline in care day utilization from FY 2020 through FY 2022 is due in large part to a decline in admissions to care that began in FY 2019 and escalated during the COVID-19 pandemic (see Figure ES-3). Similar to the change in total care days, the number of child entries was fairly stable during the baseline period and into FY 2018, declined slightly in FY 2019, then declined more dramatically in FY 2020, and continued to drop in FY 2021 and FY 2022. In FY 2020, there was a 43 percent drop in the number of children entering care compared to FY 2019, and child entries continued to decline in 2021 and dropped 13 percent in FY 2022 compared to FY 2021. Child exits and the caseload count also declined in FY 2020 through FY 2022 compared to previous years. In FY 2022, the caseload count declined by 10 percent, relative to FY 2021, and exits dropped by 27 percent.

Figure ES-3. Kent County child entries, exits, and caseload count at the end of the Fiscal Year



Length of stay also impacts care day utilization. Figure ES-4 compares median duration in Kent County to the rest of the state. Median duration was somewhat higher than the rest of the state in the 2 years leading up to the pilot (FYs 2016-2017) and remained higher for the first 2 years of the pilot (FYs 2018-2019). For children entering care in FY 2018 and FY 2019, it took about 3 months longer for the first half of the cohort to exit care in Kent County than the rest of the state. Kent County's median duration dropped to 17 months for children entering care in FY 2020, nearly 4 months shorter than the rest of the state. This drop in duration corresponds to a statewide Rapid Permanency initiative implemented in April 2020.[8] For the FY 2021 entry cohort, median duration in Kent County increased to 21.7 months, which is slightly higher than the rest of the state (20.4 months).

Figure ES-4. Median duration in months by state Fiscal Year of child entry in Kent County and the rest of the state

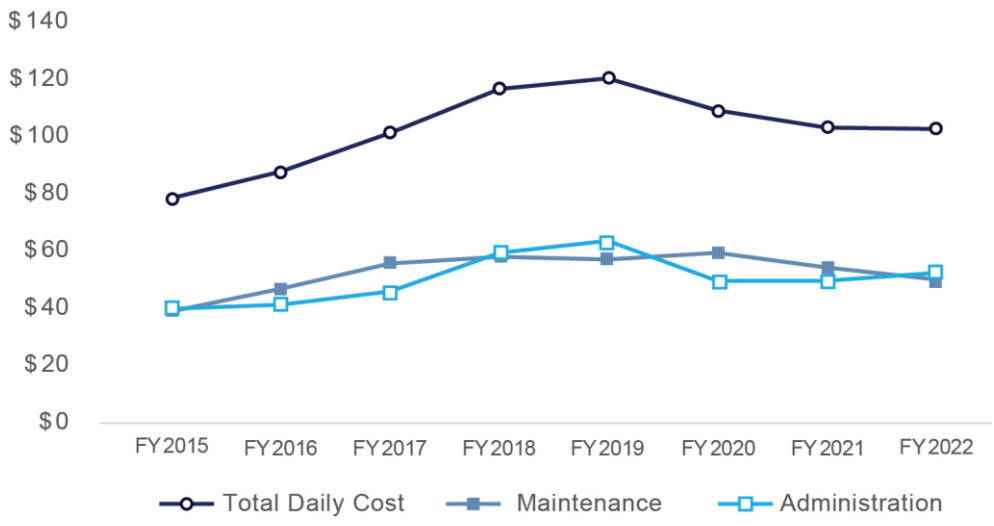


The Average Daily Unit Cost of Care

"Average unit costs" are calculated by dividing the total annual placement expenditures by total placement days for each Fiscal Year. In Kent County, for out-of-home placements the overall average daily cost per care day increased each observable year from FY 2015 through FY 2019 (Figure ES-5). The largest increase in average daily unit cost occurred during the baseline period (FYs 2015-2017), when the average daily unit cost increased by 29 percent. The average daily unit cost rose during the first 2 years of implementation (FYs 2018-2019) and decreased between FY 2020 through FY 2022. From the 2019 high, the average daily unit cost decreased 17 percent by FY 2022. In the last 2 years, the average daily unit costs of care have returned to pre-pilot levels in Kent County. In FY 2022, the average daily cost of care was 1 percent higher than it was in FY 2017 after adjusting for inflation.

[8] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

Figure ES-5. WMPC-related average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation



The average daily administrative cost increased by 15 percent during the baseline period (FYs 2015-2017) and continued to rise during the first 2 years of the pilot. By FY 2019, the average daily administrative cost of a placement increased by 40 percent above FY 2017 levels. This increase was fueled by increases in the administrative daily rate paid to providers at both the state- and WMPC-levels. FY 2020 saw a decrease in the average daily administrative rate, as WMPC adjusted the daily rate being paid to providers from $48 to $46.20, leading to a small reduction of the average daily (administrative) unit cost (1%) between FY 2020 and FY 2021. Administrative daily unit costs started to increase again in FY 2022 when the Private Agency Foster Care (PAFC) admin rate was raised to $55.20 across the state. Average daily maintenance costs fluctuated during the pilot. The average daily maintenance cost of foster care stayed fairly steady from the pre-implementation period to the pilot period. However, the average daily maintenance cost of CCI placements increased 44 percent during the pilot. The average daily maintenance cost of CCI placements was approximately $350 during the pre-implementation period up to FY 2020, and then increased to over $430 per day in FY 2021 and reached nearly $500 per day in FY 2022. The increased cost is a combination of higher level CCI placements (e.g., mental and behavioral health stabilization) and statewide increased per diem rates for qualified residential treatment programs (QRTP) in April 2021. As a result, while WMPC decreased utilization of congregate care while increasing days spent in less costly EFC, the increased cost per day for CCI placements counteracted some of the savings reflected in the overall average daily unit cost of care.

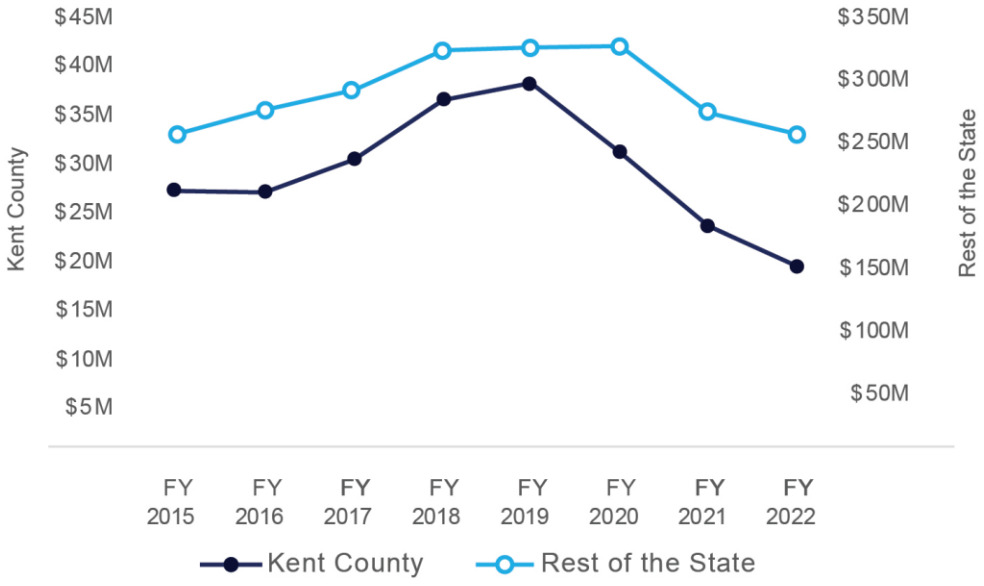
Comparing Kent County to the Rest of the State

Research Question: How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?

Figure ES-6 lays the costs trajectory in Kent County atop that in the rest of the state to enable comparison of the trend lines despite the differences in volume of total costs. During the baseline period, the rest of the state saw a 14 percent increase while Kent County saw theirs increase by 12 percent. However, during the pilot period, the rest of the state saw total child welfare expenditures plateau between FY 2018 and FY 2020, while Kent County's expenditures increased

slightly in FY 2019 and then dropped in FY 2020. In FY 2021 and FY 2022, expenditures declined in Kent County and across the rest of the state, but the decline was more rapid in Kent County.

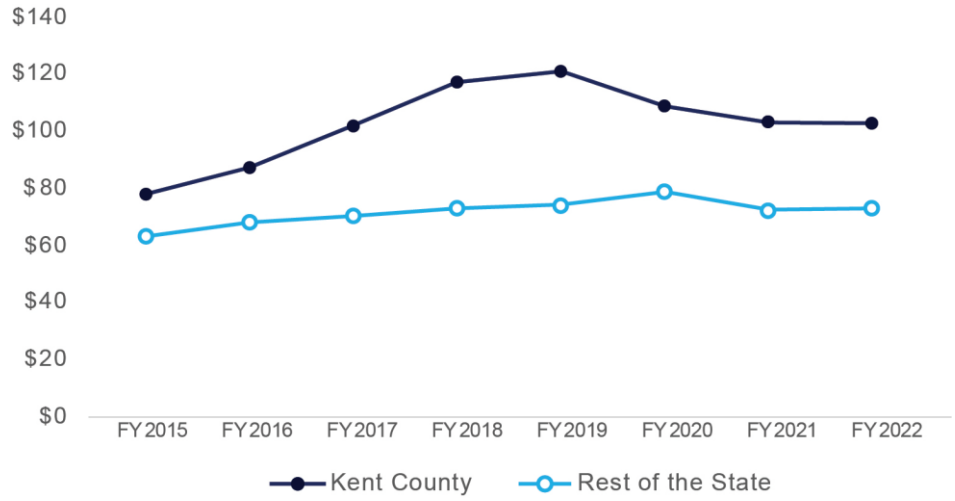
Figure ES-6. Kent County and the rest of the state – Total child welfare expenditure trends by Fiscal Year, adjusted for inflation



Another way to compare costs between Kent County and the rest of the state is the average daily unit cost of care. Figure ES-7 compares the total average daily unit cost of care in Kent County to the rest of the state. In FY 2015, Kent County's average daily unit cost was 23 percent higher than the rest of the state. This difference grew to 43 percent higher in FY 2017. The average daily unit cost in care grew slowly and steadily in the rest of the state until dipping in FY 2021 and remaining steady in FY 2022, while Kent County saw greater variability. In FY 2022, the average daily unit cost in Kent County was 40 percent higher than the rest of the state. Average daily unit costs fluctuated more in Kent County than they did in the rest of the state, but ended closer to pre-pilot levels—compared to FY 2017 levels (the last pre-pilot year), average daily unit costs in Kent County were 1 percent higher by FY 2022, and in the rest of the state, they were 4 percent higher.

As discussed previously, Kent's higher daily unit costs are related to placement agency administrative costs and utilization of more costly care types. From FY 2017 to FY 2022, the average daily cost of CCI maintenance increased 44 percent in Kent County and by only 3 percent in the rest of the state. There was a statewide rate increase for qualified residential treatment programs in April 2021, but this does not fully explain the rise in costs. The increased costs in Kent County are associated with placements in congregate settings with higher per diem rates (e.g., lower staffing ratios), which may be a result of increased acuity and/or an indirect result of a change to the approval process for residential placements during the pilot.

Figure ES-7. WMPC-related and the rest of the state – Average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation



Funding Model Sufficiency

Research Question: To what extent does the WMPC case rate (and subsequent capitated rate) fully cover the cost of services required under the contract?

For the first 3 years of the pilot (FYs 2018-2020), WMPC paid for services via a semi-annual case rate payment. However, at the end of FY 2019, case rate revenue was found to be $5.5 million short of covering expenditures. The cost study team conducted a review of the factors contributing to this shortfall in 2020 and found that WMPC fiscal policy changes explained most of the deficit. The policies that had the largest impact were 1) implementing paid kinship care before the rest of the state, 2) increasing the PAFC administrative rate, 3) increasing CCI maintenance costs associated with changing the approval process for residential care placements, and 4) paying for shelter bed capacity instead of occupancy.

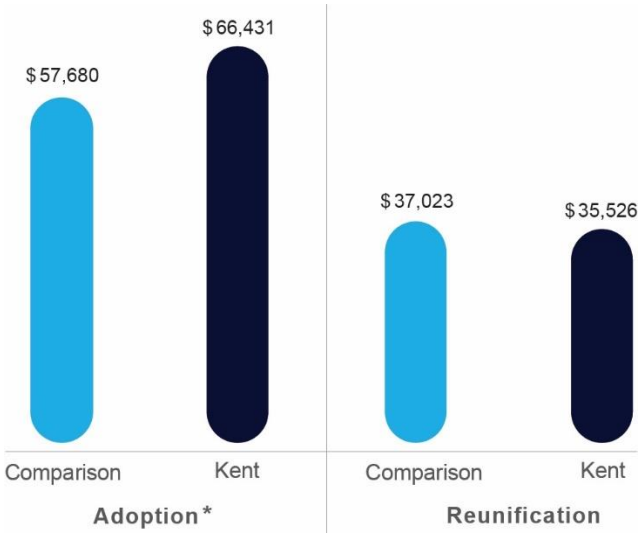
Beginning in FY 2021, the pilot shifted to a capitated allocation model. The allocation amount was developed by Public Consulting Group (PCG) based on historic spending and the average number of children served in Kent County—$36,975,656 for FY 2021, which was lowered to $34,467,356 for FY 2022. The WMPC administration rate increased in FY 2023 from $2,000,000 to $2,194,000 to include the raised Detroit Consumer Price Index. The cost study team has monitored spending under the capped allocation on a quarterly basis, using care day projections to estimate spending against the capped allocation before the end of the year. Each cost monitoring memo between FY 2021 and FY 2022 has shown that WMPC is spending substantially less than the capped allocation. Based on the $23.6 million for FY 2021 and $19.5 million for FY 2022 in private agency expenditures (excludes WMPC administration) shown in Table ES-1, WMPC spent approximately 60 percent of the capped allocation over the past 2 years, leaving a surplus of more than $28 million for FYs 2021 and 2022 combined. As discussed earlier, the large surplus is driven by reduced admissions and care day utilization in FYs 2020 through 2022 compared to the earlier years on which the capped allocation amount was based. In addition, several of the WMPC policies (e.g., higher PAFC administrative rates) that contributed to higher costs than the case rate could support, were discontinued. Reduced utilization of CCI care days and shorter length of stay for the FY 2020 entry cohort also contributed to lower costs.

Cost Effectiveness Analyses

Research Question: What are the cost implications of the outcomes observed under the transition to the Kent Model?

The child-level costs by the two most common discharge reasons (adoption and reunification, see Table ES-5 in the outcome section) are summarized in Figure ES-8. These are the total maintenance and administrative costs accumulated during an out-of-home placement spell. For children entering care after the pilot began, the average cost of achieving reunification was 4 percent lower in Kent County ($35,526) than in the comparison group ($37,023), which may correspond with a shorter time to reunification observed by the outcome study (see Table ES-6). However, this difference was not statistically significant in terms of costs. The average cost of completing an adoption for children who entered care after the pilot began was significantly higher in Kent County than in the comparison group—$66,431 compared to $57,680 (p=0.003). The outcome study did not find a significant difference in the time to adoption, but Kent County tends to have a higher average daily cost of care, which could explain why adoptions cost slightly more.

Figure ES-8. Average cost per out-of-home placement spell for children entering care after 10/01/2017 and discharged from care as of 10/01/2022



* Indicates p<0.05

Outcome Study

The propensity score matching (PSM) method for creating the comparison group resulted in equivalent groups (e.g., no statistically significant differences across race, ethnicity, gender, and age). These groups include:

1. Children in care in Kent County prior to 10/1/2017.
2. A matched group of children associated with counties other than Kent County prior to 10/1/2017.
3. Children in care in Kent County after 10/1/2017.
4. A matched group of children associated with counties other than Kent County after 10/1/2017.

Unless otherwise specified, comparisons are made between total populations in Kent County and the comparison group (i.e., groups 1 and 3 above, versus groups 2 and 4 above), and children in care after 10/1/2017 in Kent County and the comparison group (i.e., groups 3 and 4 above).

Research Question: Does the Kent Model improve the safety of children? Analysis of data on maltreatment recurrence and maltreatment in care indicated that there were no statistically significant differences between children served in Kent County and children in the matched comparison group in regard to safety.

Research Question: Does the Kent Model improve permanency for children? As shown in Table ES-3 children in Kent County who entered care after 10/1/2017 and exited, tended to stay fewer days in care, on average, than children in the comparison group (563 days versus 643 days); this difference is statistically significant (*p*-value <0.05).

Table ES-3. Exited or still in care

Group	Exit status	% (N)	Length of stay		
			Mean	Standard deviation	Median
Comparison, entered care after 10/01/2017	In care	34.4% (444)	688.6	475	548.5
	Exited	**65.6% (848)**	**642.5**	358.3	596.5
Comparison, in care prior to 10/01/2017 (legacy)	In care	4.4% (34)	2,280.3	356.1	2,157.5
	Exited	95.6% (736)	987.9	523.7	872.5
Kent, entered care after 10/01/2017	In care	30.2% (397)	623.7	447.2	533
	Exited	**69.8% (917)**$^{+}$	**563.2***	361.8	545
Kent, in care prior to 10/01/2017 (legacy)	In care	3.0% (23)	2,852.9	853.6	2,563.0
	Exited	97.0% (740)	955.7	521.4	839

* Indicates $p<0.05$, $^{+}$ indicates $p<0.001$.

Table ES-4 shows cumulative exits to permanency at 6, 12, and 18 months for all children who exited with each increase in time frame. A higher percentage of children in Kent County who entered care after 10/1/2017 achieved permanency within 6 months of entering care at a statistically higher rate than children in the comparison counties (15.4% vs. 8.8%, p-value <0.0001). This difference is maintained by the 12th month (28.4% vs. 23.2%, p-value <0.001) but is not observed by the 18th month.

Table ES-4. Cumulative exits to permanency

Group	Permanency within 6 months	Permanency within 12 months	Permanency within 18 months	Ever achieved permanency	Total exits (N = 3,241)
Comparison, entered care after 10/01/2017	**8.8% (75)**	**23.2% (197)**	39.9% (380)	87.85% (745)	848
Comparison, in care prior to 10/01/2017	2.2% (16)	7.5% (55)	16.6% (122)	84.38% (621)	736
Kent, entered care after 10/01/2017	**15.4% (141)⁺⁺**	**28.4% (260)⁺**	41.4% (380)	87.68% (804)	917
Kent, in care prior to 10/01/2017	1.4% (10)	4.9% (36)	15.8% (117)	86.76% (642)	740

⁺ Indicates $p<0.001$, ⁺⁺ indicates $p<0.0001$.

The study team used the survival analysis method to measure the rate of exits to permanency over time for the first 24 months in care. They found that among children who entered care after 10/1/2017, children in Kent County exit to permanency at a significantly faster rate than children in the comparison group (p-value <0.001) (Figure ES-9).

Figure ES-9. Permanency survival rate for study groups

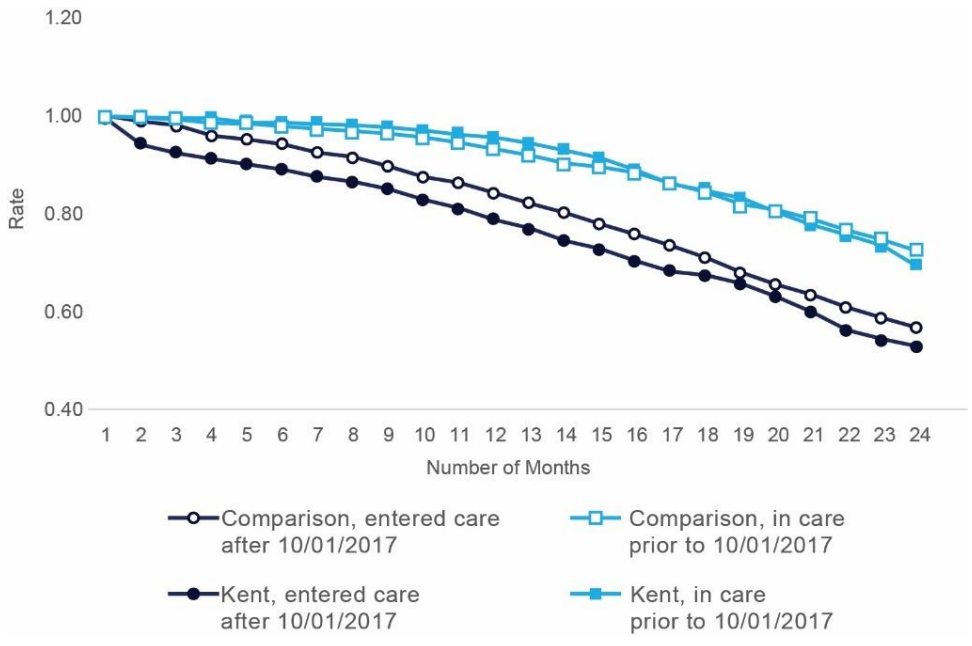


Table ES-5 shows that for children who entered care after 10/1/2017, those in Kent County exited to adoption at a *lower* rate than children in the comparison group (p-value <0.05).

Table ES-5. Permanency categories by study group

Group	Adoption	Guardianship	Living with other relatives	Reunification with parents or primary caretakers
Comparison, entered care after 10/01/2017	**39.2% (292)**	7.7% (57)	0.8% (6)	52.3% (390)
Comparison, in care prior to 10/01/2017	62.8% (390)	6.4% (40)	0.0% (0)	30.8% (191)
Kent, entered care after 10/01/2017	**33.2% (267)***	10.2% (82)	1.1% (9)	55.5% (446)
Kent, in care prior to 10/01/2017	56.9% (365)	10.0% (64)	0.9% (6)	32.2% (207)

* Indicates p<0.05; bolded figures indicate the comparison yielding the significant results.

As shown in Table ES-6, children served through the Kent Model who entered care after 10/1/2017 exited to reunification faster than those in the comparison group (359.5 versus 409.0 days); this difference is statistically significant (p-value <0.001).

Table ES-6. Time to exit by permanency type

Group	Exit type	N	Time to exit		
			Mean	Median	Standard deviation
Comparison, entered care after 10/01/2017	Adoption	292	836.0	841.8	321.2
	Guardianship	57	716.0	718.1	358.8
	Living With Other Relatives	6	524.0	431.7	303.6
	Reunification With Parents or Primary Caretakers	390	**409.0**	503.3	374.5
Comparison, in care prior to 10/01/2017	Adoption	390	958.5	1,051.7	441.1
	Guardianship	40	908.5	1,041.0	707.2
	Reunification With Parents or Primary Caretakers	191	571.0	745.6	513.7
Kent, entered care after 10/01/2017	Adoption	267	834.0	852.1	263.0
	Guardianship	82	734.5	688.2	328.5
	Living With Other Relatives	9	13.0	54.6	58.7
	Reunification With Parents or Primary Caretakers	446	**359.5+**	416.6	333.7
Kent, in care prior to 10/01/2017	Adoption	365	959.0	1,027.6	420.7
	Guardianship	64	799.0	824.2	314.7
	Living With Other Relatives	6	1,265.0	1,457.2	673.9
	Reunification With Parents or Primary Caretakers	207	599.0	759.7	512.0

+ Indicates p<0.001; bolded figures indicate the comparison yielding significant results.

Research Question: Does the Kent Model improve children's placement stability? Children in Kent County experienced two or more placement changes at a rate similar to children outside Kent County.

Process Study

Kent Model Implementation

Research Question: Do the counties adhere to the state's guiding principles in performing child welfare practice?

A key element of the Kent Model has been the Care Coordination structure, which assigns a designated Care Coordinator to each private agency. The Care Coordinator serves as a facilitator for service approvals, a liaison with WMPC, an intermediary between private agencies and Kent County DHHS, and a source of information, assistance, and support to foster care caseworkers. The success of care coordination depends on having the right person in the coordinator role, along with strong management of the overall program. In the final year of data collection, respondents at each of the private agencies said that they feel supported by their current Care Coordinator.

Since the start of implementation, EFC has been described as the most positively received component of the Kent Model. Through EFC, caregivers receive a higher foster care rate and intensive in-home services for children with higher needs. In the third year of implementation, WMPC instituted a per-agency cap on EFC cases and a process for regular case review. The cap and review process were intended to control EFC expenditures and ensure that EFC was being used as intended. In the most recent focus groups, private agency staff agreed that they were managing under the caps, but also perceived that there was an increased demand for EFC services due to statewide reductions in the availability of residential care and a higher proportion of children with high needs entering foster care.

Research Questions: What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services? What resources are necessary to support the successful implementation of the Kent Model?

Increased flexibility. An important aspect of the Kent Model is greater financial flexibility for private agency staff to develop and implement innovative solutions to better meet the needs of children and families in the foster care system in Kent County. Early in the pilot, WMPC paid private agencies a staffing rate of $48, higher than the statewide rate of $46.20. In focus groups, private agency leadership and staff reported that private agencies used funding from the higher staffing rate to fund additional positions such as family finders, case aides, buffer workers (to help fill staffing gaps), and supervisors. In Year 4, WMPC lowered the rate to the statewide rate, prompting some agency leaders to identify alternate funding sources to retain these positions. However, MDHHS received additional 2022 Fiscal Year appropriations, enabling the agency to raise the staffing rate to $55.20 statewide. Additionally, most private agency respondents agreed that miscellaneous funding requests allow for greater creativity in case planning (e.g., medical or behavioral health services that could not be paid for through Medicaid). At a system level, WMPC also sought to facilitate innovation by bringing the private agencies together to share innovative processes and practices with each other.

Interagency collaboration. After the first year of pilot implementation, respondents described the relationship between Kent County DHHS and the five private child-serving agencies in Kent County as highly collaborative on the administrative level but tense on the line-staff level due to changes in roles and previous collaborative difficulties. In the second year, respondents at all levels described significant improvements in the collaborative relationships through the efforts of DHHS and WMPC leadership to work out previous points of tension, such as the case transfer process and funding approvals. In the final 2 years of the evaluation, respondents at Kent County DHHS, WMPC, and the private agencies described collaboration across the public/private divide as going smoothly.

Local partners played an integral role in supporting families served through the pilot. Over the years, judges and court staff interviewed have given positive feedback regarding the changes the Kent Model has brought to the child welfare system (e.g., faster service referrals). In terms of the partnership with the local mental health system, during early implementation of the Kent Model, private agency staff expressed frustration in connecting families with mental health services through Network 180. WMPC and Network 180 created a Clinical Liaison position based at WMPC to help assess children's mental health needs and to recommend appropriate services. By the end of the evaluation, most private agency staff agreed that the Clinical Liaison helped them identify services they might not know about, but they still had difficulty obtaining some services for families (e.g., they may not quality if they do not meet Medicaid eligibility criteria).

Service referrals. Efficiency and consistency in processing service requests was a major pre-implementation issue for private agency staff who expressed increased satisfaction with the process each year since implementation began. Consistent in the final 2 years of the evaluation, private agency staff reported that service referrals now run mostly smooth and have a reasonable turnaround time with both WMPC and Kent County DHHS.

Performance and quality improvement (PQI). WMPC's PQI team encountered a number of challenges throughout the evaluation period, including frequent turnover and restructuring, creating continuous quality improvement processes while building the infrastructure, and experiencing a delay of MindShare (data reporting system) implementation by nearly 2 years. Despite these challenges, the PQI team has continued to streamline processes and now produce reports and data analytics as originally envisioned. In Year 4 of the pilot, WMPC used predictive analytics to allocate services and resources more effectively, and the majority of private agency respondents reported support for WMPC PQI efforts. Nearly all the private agencies created specific staff positions that focus on PQI, data, and utilization management.

Utilization management. One substantial shift in Year 2 of implementation was the move to a fully integrated utilization management program focused on achieving permanency within 12 months by managing residential utilization and EFC services. At the end of the evaluation period, WMPC was in the early stages of implementing a new Clinical Utilization Manager position, developed as a result of an agency-wide analysis that identified utilization management as the *"center point"* between PQI and care coordination.

Facilitators and Barriers

Research Question: What factors facilitate and inhibit effective implementation of child welfare practice, in general, and, importantly, in the Kent Model (in Kent County)?

Facilitators to implementation. During the final data collection period, representatives from Kent County DHHS, all five private agencies, and WMPC identified EFC as the most important initiative that was introduced during the pilot that helps agency staff meet the needs of the families they serve. Another aspect of the Kent Model that respondents from all agencies and WMPC identified as being most important in helping agency staff meet clients' needs is the funding flexibility and the ability of agency staff to apply creativity to case planning. Respondents identified other important features of the pilot, which include WMPC's structure and operation (e.g., care coordination), increased collaboration and coordination among private agencies and WMPC, a higher case rate to support foster care providers and augment agency staff, the ability to obtain service approvals internally from agency leadership, expedited responses to requests for funding, and increased use of data to drive decisions.

> ***"Enhanced foster care is such a unique approach in this pilot and is probably the absolute best thing that has come out of it."***
>
> –Agency leader

Barriers to implementation. Respondents from several agencies discussed the challenges that staff turnover presents. As one supervisor explained, *"You start to get used to the style of a specific person in a role or they start to become familiar with your processes or your cases, and then they're gone."* Respondents from multiple agencies also identified limited availability of services for their clients; misalignment between their expectations for collaboration with WMPC and among agencies, and the extent to which agency/organizational staff actually work collaboratively; inadequate communication; and dissatisfaction with the extent to which and how data is used and interpreted as challenges. Other factors that respondents from multiple agencies identified as barriers to service provision through the pilot include WMPC adding *"another layer"* to collaborative structures that existed prior to the pilot, and a lack of clarity about specific aspects of the pilot, such as requirements, processes, and roles.

> ***"We had someone [from WMPC] in the office once a week and now they can't really come to us because they don't even live near us."***
>
> –Agency supervisor

Recommendations and Lessons Learned

Interagency collaboration following the pilot. Respondents from two different private agencies would appreciate having more opportunities to engage in shared decisionmaking with Kent County DHHS staff. Respondents also mentioned the value of having face-to-face contact with Kent County DHHS staff to build and maintain rapport. Relatedly, some respondents from private agencies appreciate having one WMPC Care Coordinator assigned to their agency, as opposed to multiple Kent County DHHS monitors assigned to one agency prior to the pilot. While interview and focus group respondents from nearly all the private agencies reported that they appreciate WMPC's flexibility around funding

> ***"I think it's important [for organization and agency representatives] to have connections and build rapport, just like we would do with clients."***
>
> –Agency supervisor

for services and exchanging ideas with Care Coordinators to identify creative solutions to case challenges, some respondents also discussed the need for more support from WMPC.

Recommendations performance-based model implementation. Respondents recommended that an entity like WMPC that will implement a similar funding model should establish and maintain effective collaborative relationships; ensure all organization staff is based in the community where the model is implemented; recruit appropriate staff, consultants, and leaders; and maintain active engagement with agency staff. Respondents also provided recommendations for state DHHS agency leaders, who will fund and oversee a performance-based model, and local provider agency directors. The former should outline and communicate expectations for the model, support and advocate for model implementation, and enable county agencies to have decision-making authority. Respondents recommended that private agency directors clarify and define roles and expectations, support and communicate to staff about model implementation, and build and maintain collaborative relationships with decisionmakers and staff at other private agencies.

Ingham and Oakland Counties

Agency staff in Ingham and Oakland counties, the comparison counties for the process study, described experiences that were similar to those described by staff in Kent County, relative to topics such as the barriers related to frequent staff turnover (e.g., increased workloads) and strengths and challenges to partnering with mental health agencies and the court system (e.g., waiting lists for mental health services). The experiences diverged relative to service approval processes, service availability, and collaboration with the county DHHS agency.

Service approval process. Private agency staff and leaders in comparison counties reported that the service approval process can take a considerable amount of time, due to communication issues, type and cost of service requested, incomplete information provided to the county DHHS agency, and a multi-layered approval process. While lengthy service approval processes were a persistent theme among respondents from comparison counties for most of the evaluation, the opposite was true among agency staff in Kent County. For the most part, WMPC expedited these processes.

Service availability. Agency staff from all three counties expressed frustration with the limited availability of some services for clients (e.g., mental health services, substance use screening). There are often waiting lists for certain services, there is an inadequate number of providers offering some needed services, and agency staff often have difficulty locating services that are necessary to meet a family's needs. Some services are available to families in Kent County as a result of the pilot (e.g., EFC). The implication is that although service availability is a common challenge in all three counties, families in Kent County have benefited from having access to support services they may not have received if it were not for the Kent Model.

Collaboration with DHHS. Private and public agency staff in Kent County have limited interactions given that the WMPC serves as the *"middle man."* In Ingham and Oakland counties, private agency staff must engage frequently with staff from the county DHHS agency as part of case practice (e.g., to seek approval for service requests). Overall, respondents from private and public agencies in the comparison counties described their relationships as collaborative and collegial, which they attributed to open lines of communication, responsiveness, positive rapport and trust, regular inter-agency leadership interactions, inter-agency trainings, and long tenure of staff at the county DHHS agency. Private agency staff in Ingham and Oakland counties also described challenges to collaborating with DHHS staff, which included communication issues, a perception that there was a lack of support from DHHS staff (e.g., *"Sometimes it very much feels like us against them or them*

against us"), and disagreement on family goals. DHHS agency staff reported having difficulty navigating multiple agencies with different policies and procedures, and expressed frustration with case assignment (e.g., DHHS staff must manage cases that private agency staff decline), and frequent turnover in private agencies that in turn require additional DHHS oversight.

E4. Summary and Conclusions

The 6-year Kent Model evaluation enabled the study team to examine changes in **costs** associated with the Kent Model, **outcomes** for children in care (safety, permanency, and stability), and agency and staff **processes** for supporting and engaging in effective case practice.

Total private agency expenditures in Kent County increased from the pre-implementation period (FYs 2015-2017) through the first 2 years of the pilot (FYs 2018-2019) before decreasing from FY 2020 through the end of the evaluation (FY 2022). Private agency expenditure trends in the county are driven by placement costs, as nearly all expenditures are related to placement maintenance and administration. In Kent County and across the state, CCIs composed the largest proportion of placement expenditures. Expenditure decreases were largely due to a decline in the number of children entering care and decreased care day utilization, particularly between FYs 2019 and 2020, with continued decreases through FY 2022.

Overall care day utilization shifted slightly to less restrictive, less costly settings during the pilot. Placement days spent in kinship care increased after WMPC implemented paid kinship care, although the rest of the state continues to use more kinship care than Kent County. Utilization of EFC increased during the pilot while days spent in congregate settings decreased. EFC is intended to provide a less restrictive, lower cost alternative to CCI. However, some of the potential savings from EFC were offset by high-level CCI placements; the average daily maintenance unit cost of CCI placements increased by 44 percent during the pilot while the rest of the state maintained relatively stable costs. Consequently, expanding EFC and placing children in the lowest level of congregate care possible could reduce costs.

Cost effectiveness analyses revealed that there was not a significant difference in the cost of achieving reunification, and a slightly higher cost of achieving adoption for children in Kent County compared to the matched group. The slightly higher cost of adoption can be linked to Kent County's higher average daily unit costs of care, and longer lengths of stay for children entering care during the first 2 years of the pilot. WMPC lowered costs in FY 2020 in part by decreasing the PAFC rate to state levels. Simultaneously, length of stay decreased for the FY 2020 entry cohort. However, median duration increased again for the FY 2021 entry cohort and these savings may not be sustained. WMPC could make strategic investments to reduce length of stay. For example, the statewide Rapid Permanency initiative implemented in April 2020[9] may have contributed to the shorter durations observed for the FY 2020 entry cohort. Additionally, prospective payment models inherently incentivize reduced length of stay—compared to traditional fee-for-service models that may promote overutilization—because providers retain excess revenue when children reach permanency more quickly (see Appendix E).

However, neither of the prospective funding models used during the pilot provided WMPC with an appropriate level of revenue. The case rate model used for the first 3 years of the pilot fell short of

[9] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

actual expenditures, largely due to WMPC policies (e.g., higher PAFC administrative rates and paid kinship care). Beginning in FY 2021, the pilot switched to a capitated allocation model that greatly overfunded the pilot, in part due to a large decline in the number of children entering care. Moving forward, the cost study team recommends shifting to a prospective payment model that uses care day utilization and child placement trends to project the allocation amount (see Appendix E). The revised fiscal model could also create an incentive structure for providers to make investments in the quality and process of care with the goal of improving outcomes.

Outcomes for children in Kent County were similar to the comparison group in the areas of safety (maltreatment in care and recurrence) and placement stability. For permanency outcomes, the study team found that children in Kent County exited to permanency at a higher rate at 6 and 12 months. These results imply that policy or practice changes made through the Kent Model increased the rate of children achieving permanency without compromising their safety. Because differences were not significant among children who exited to permanency within 18 months, to innovate the project further, more investigation could be done to determine why the difference disappears and for which children.

Throughout the course of Kent Model implementation, representatives from WMPC, Kent County DHHS, and private agencies described beneficial changes associated with the Kent Model, which could be implied as successful aspects of the pilot. These elements are **EFC;** having a **single point of contact** for service approvals, case monitoring, guidance, and support; having opportunities for staff to engage in inter-agency **collaboration** to share best practices and innovations; having **flexibility** in how agency staff use funding and apply **creativity** to case planning; and WMPC's application of a **utilization management approach.** There were also factors that impeded implementation. These elements are **staff turnover,** particularly among Care Coordinators whom private agency staff rely on for support and guidance; WMPC's **fiscal crisis,** which prompted adjustments in pilot management and administration; Care Coordinators being **located outside the community,** limiting their awareness of the local context for service provision and their accessibility to agency staff they support; and aspects of **data reporting and extraction** processes that made it difficult to accurately interpret and use data.

As with any new initiative, hurdles are to be expected, as are new processes that may lead to positive outcomes. This report described barriers to Kent Model implementation that were balanced with the introduction of valuable new initiatives and processes. Relatedly, during the final round of data collection for the process study (with participation from Kent County agency staff who had been with the agency since the pilot began as well as MDHHS leadership), the study team asked interview and focus group respondents for one word they would use to describe the Kent Model (Exhibit ES-1). The responses were mixed—some words were positive and others gave the impression that respondents would do things differently if given the opportunity. The most commonly used Kent Model descriptors were *"creative"* and *"collaborative"* followed by words such as *"disappointing"* and *"underwhelming."*

Overall, results for continuation of the initiative as a whole were inconclusive. The evaluation team recommends continuation of some components, while revising other components of the Kent Model. The Kent Model, like other programs and initiatives, has many different components that were implemented with varying levels of success. Additionally, the COVID-19 pandemic was an unprecedented event that occurred during Kent Model implementation. The pandemic led to unplanned disruptions and prompted immediate adjustments

Exhibit ES-1. Words used to describe the Kent Model

to how services were delivered. For these reasons, it is difficult to make an overall statement regarding Kent Model effectiveness. However, although evaluation results were mixed, some of the results uncovered promising policies and practices, which offers evidence of Kent Model strengths as well as areas for improvement.

Outcomes for children in Kent County were similar to or better than outcomes for children in the comparison group. Additionally, WMPC faced fiscal challenges but pivoted to identify strategies for supporting private agency staff needs and managing financial obligations. WMPC implemented policies and procedures that were intended to help agency staff serve children in care more effectively. Some were strongly supported while others were described as impeding service delivery. Taken together, evaluation results imply that it is appropriate to maintain ***components*** of the Kent Model that were described in positive terms in Section E3 and earlier in Section E4. For example, EFC helped agency staff serve families with children in care more effectively and reduced time in more costly placement settings (e.g., CCI). Neither the case rate funding model nor capitated allocation funding model provided WMPC with an appropriate level of revenue, leading the cost study team to recommend a prospective payment model that uses care day utilization and child placement trends to project the allocation amount. The revised fiscal model could also create an incentive structure for providers to make investments in the quality and process of care with the goal of improving outcomes. The evaluation team suggests modifying or eliminating Kent Model components that were barriers to service delivery (e.g., policies regarding data use and its interpretation to improve the quality and accuracy of data used to improve case practice). In a subsequent evaluation, MDHHS may benefit from further exploration of factors that contribute to outcomes (e.g., the rate at which children exit care to permanency and the permanency type to which they exit, such as adoption or reunification).

1. Introduction

1.1 Pilot Model

Child welfare services in Michigan are administered through the Michigan Department of Health and Human Services' (MDHHS') Children's Service Administration. Public and private child placing agencies across the state are expected to promote safety, permanency, and well-being in the families they serve through approximately 13 guiding principles, including, for example, that safety is the first priority of the child welfare system; the ideal place for children is with their families, therefore, agencies will ensure children remain in their own homes whenever safely possible; services are tailored to families and children to meet their unique needs; and decisions are outcome-based, research-driven, and continuously evaluated for improvement. Agencies are expected to integrate these guiding principles into their policies and practices.

The Michigan Legislature, through Public Act 59 of 2013, Section 503, convened a task force to determine the feasibility of establishing performance-based funding for public and private child welfare service providers. A recommendation from the task force called for a pilot project to plan, implement, and evaluate the new funding model (referred to in this report as the Kent Model). The Kent Model is being implemented by the West Michigan Partnership for Children (WMPC). WMPC is an organization that partners with five private Kent County-based service agencies and was created to pilot the performance-based funding model[10] with the goal of improving outcomes for children (www.wmpc.care).

The Kent Model is being tested to determine if, in combination with the aforementioned guiding principles, the funding model provides for more flexible and efficient programming and services for child welfare-involved families and ultimately produces more effective outcomes for families and their children, especially those experiencing out-of-home care. These components are the foundation of the overall evaluation.

1.2 Kent Model Evaluation

In addition to the task force's recommendation for Kent Model planning and implementation, it also called for an independent evaluation of the pilot to assess the planning and implementation required of such a project, the cost effectiveness, and the child and family outcomes associated with it. The evaluation contract was awarded to Westat and its partners in 2016 and includes cost (Chapin Hall), outcome (University of Michigan School of Social Work), and process (Westat) components.

Overall, the rigorous 5-year evaluation of the pilot was designed to test the effectiveness of the Kent Model on child and family outcomes in Kent County. The outcome and cost components of the evaluation are designed to compare the Kent Model to the per diem model ("business as usual") for foster care services being implemented across the state. The cost study addresses cost effectiveness in service delivery, the outcome study documents change in child and family outcomes (i.e., safety,

[10] In 2021, MDHHS' contract agreement with WMPC was revised to reflect the shift from a case rate to a capitated payment model (https://www.michigan.gov/documents/mdhhs/Section_5043_PA_166_of_2020_719406_7.pdf).

permanency, and well-being), and the process study provides the context for foster care service implementation. While the comparison group for the cost and outcomes studies are all counties in Michigan other than Kent County, Ingham and Oakland counties served as the comparison counties for the process study.

1.3 Report Overview

This report provides results for the last data collection period, from October 2021 to September 2022, and recapitulates findings over the full 5-year pilot period. In addition to the Introduction (Chapter 1), there are three other chapters: Chapter 2, Methodology, which describes methods used to answer the research questions; Chapter 3, Results, which provides a summary of key findings from the cost, outcome, and process studies; and Chapter 4, Summary and Conclusions, which summarizes cross-study results and provides evaluation implications.

2. Methodology

The purpose of this evaluation is to rigorously test whether the pilot (i.e., Kent Model) produces improved outcomes for children and families, is cost effective, and allows for the effective allocation of resources to promote local service innovation, create service efficiencies, and incentivize child placing agencies to be accountable for achieving performance standards.

Overarching Design: Matched Comparison Model Combined with a Descriptive Qualitative Approach

This evaluation provides the team with an opportunity to combine two methodologies into one overall design. First, the outcome and cost studies are based on a matched comparison design. This design allows administrative outcome (safety, permanency, and well-being) and cost data associated with the Kent Model to be compared with those for the per diem model using matched comparison groups drawn from across the state and developed using propensity score matching (PSM). These comparisons allow the evaluation team to answer the research questions of interest. Through the process evaluation, the team examines and explains *how* case practice is conducted in Kent and comparison counties, including internal (e.g., agency policies) and external (e.g., interagency collaboration) factors that may influence service provision. The overall evaluation plan (e.g., research questions, indicators, methods, and data sources for the three components) is described in Appendix B.

2.1 Research Questions

The evaluation is guided by the following research questions that are relevant to each component of the evaluation (cost, outcome, and process).

Cost Component

- What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?
- How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?
- To what extent does the WMPC case rate (and subsequent capitated rate) fully cover the cost of services required under the contract?
- What are the cost implications of the outcomes observed under the transition to the Kent Model?

Outcome Component

- Does the Kent Model improve the safety of children?
- Does the Kent Model improve permanency for children?
- Does the Kent Model improve the well-being of children and families?

Process Component

- Do the counties adhere to the state's guiding principles in performing child welfare practice?
- Do child placing agencies adhere to the MiTEAM[11] practice model when providing child welfare services?
  - **Subquestion.** What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services?
  - **Subquestion.** What factors facilitate and inhibit effective implementation of child welfare practice, in general, and, importantly, the Kent Model (in Kent County)?
  - **Subquestion.** What resources are necessary to support the successful implementation of the Kent Model (in Kent County)?

2.2 Logic Model

The evaluation team created a logic model to illustrate the theory of change for the evaluation of the Kent Model (Appendix C). The logic model is a visual depiction of the theory underlying how and why certain changes are expected to occur relative to Kent Model implementation. The evaluation team is examining implementation[12] of the model, as well as outcomes associated with it, through the cost, outcome, and process studies. Primary activities carried out through the studies are captured in three streams of logic model components, or pathways of interconnected components that span from activities to outcomes. A fourth stream shows cross-cutting components, or components that are related to all three studies.

The four pathways begin with the inputs, or resources, that support and are integral to implementation of the Kent Model. Agency/organizational staff, funding, service recipients, and data and research are the key assets or resources that stakeholders rely on to implement the Kent Model. Subsequent columns in the logic model show major activities carried out through the process, outcome, and cost studies (e.g., accessing administrative data on children served by child welfare agencies in Michigan counties), as well as resulting outputs or deliverables from the activities (e.g., outcomes for children in Kent County and other Michigan counties are tracked). Finally, components in the short-, mid-, and long-term outcomes columns represent the immediate, gradual, and systemic changes that are expected to occur (e.g., improved child safety, permanency, and well-being outcomes).

2.3 Cost Study Methodology

2.3.1 Overview

The cost study is designed to understand the fiscal effects of the transition to the Kent Model using primarily system-level and child-level fiscal and placement data from Kent County. The cost study addresses the research questions (see Section 2.1) in the following ways. To address the first two

[11] Michigan's MiTEAM practice model emphasizes competence in engagement, teaming, assessment, and mentoring (https://www.michigan.gov/mdhhs/doing-business/cw-staff/strengthening-focus/miteam).

[12] As noted, planning was assessed in 2017-2018. Since then, the process evaluation has focused on implementation of the Kent Model.

research questions, the cost study team examined system-level expenditure and revenue trends in Kent County and the rest of the state, focusing on the 3-year baseline period (FY 2015 – FY 2017) and the first 5 years post-implementation (FY 2018 – FY 2022). These expenditure patterns and revenue sources were also compared with those across the state, to address the second research question. The cost study compares total expenditures, care day utilization by placement type, and per diem costs of care in Kent County and the rest of the state.

For the third research question, to understand whether the WMPC case rate (now referred to as the capitated rate) fully covers the cost of services required under the contract, the cost study team analyzed relevant data in FY 2020 and submitted results via a memo to MDHHS in October 2020. We found that case rate revenue in FY 2018 and FY 2019 was sufficient to cover all *state-initiated* reimbursement rate increases made through FY 2019 but fell short of covering *WMPC-initiated* fiscal changes. The latter includes costs related to providing enhanced foster care (EFC) and increasing the administrative rate above state levels in FYs 2018 through 2020.[13] The average daily reimbursement rate under WMPC was about $104, which is 9 percent higher than the daily revenue received.

In response to this shortfall, WMPC changed to a capitated funding model starting in FY 2021. Chapin Hall monitored spending under the capitated allocation on a quarterly basis via memos to WMPC and MDHHS. Quarterly and projected annual spending was estimated using care day utilization and child admission, caseload, and exit patterns. WMPC had a budget surplus under the capitated allocation for FYs 2021 and 2022, in large part due to decreased child admissions.

To answer the fourth question about the cost implications of child outcomes, the cost study team uses child-level fiscal data linked to child placement spells (a period during which a child is continuously in out-of-home care) to compare the cost per outcome of children in Kent County to a matched comparison group. The study team examined the type, amounts, and costs of services received by children in out-of-home placements and compared them with those provided to a matched cohort of children receiving out-of-home services delivered by private providers across the state; the outcome study team developed the comparison group using PSM.

2.3.2 Data Sources

The cost study team currently uses administrative data collected from these sources:

1. **MiSACWIS Payment Data.** This data includes only paid[14] payments where Kent County is listed as the responsible county, from 5/1/2014 through 9/30/2022, for all child and family services (at the child level) during those times when a child was in out-of-home placement up until the point of discharge. This data is categorized by their Service Domain, Service Category, and Service Description. A full mapping of these expenditure categories is in Appendix D. The data is assigned to the appropriate Fiscal Year via the Claim Begin and Claim End Dates.[15] For any payment that spans multiple Fiscal Years, the total cost is pro-rated

[13] See https://www.michigan.gov/documents/mdhhs/Section5035-PA166of020-Rpt_1_715344_7.pdf for the executive summary of WMPC's Case Rate Review Sub-Study from September 2020 for more details.

[14] All unpaid services are excluded.

[15] Claim dates in MiSACWIS represent the dates of the pay period of when the service occurred, not the dates of the actual payment for the service.

across the applicable Fiscal Years based on the number of days within the claim period in each Fiscal Year.

2. **MiSACWIS Placement Data.** These are the same child-level data the University of Michigan uses in the outcome study. The cost study uses placement data to measure care day utilization and the number of days spent in care by placement type. This data is combined with fiscal data to assess the "average daily unit cost of care" to examine how these daily out-of-home costs have changed before and after the Kent Model was first implemented (10/1/2017).[16]

3. **WMPC Actual Cost Reporting Workbook and Accruals Detail.** These quarterly workbooks include comprehensive documentation of WMPC operational costs, including administrative costs, payments to private agencies for services provided, child-level residential payments, case rate or capitated allocation revenue payments, and other revenue sources for FY 2018 through FY 2022 only (10/1/2017 – 9/30/2022). Because the WMPC Cost Report is recorded on a cash basis, this data is supplemented with accrual payment data from WMPC for private agency expenses claimed but not paid in FY 2018 through FY 2022 (and, as such, not recorded in WMPC Cost Reports for these years).[17] FY 2018 through FY 2022 data from the WMPC Cost Report and Accruals Detail used in this study include:

    A. **Child Caring Institution (CCI) Placement Payments.** Taken from the Residential Services tab Total Payments and the Accruals Detail, these CCI Placement Payments represent the full scope of the CCI maintenance costs in FY 2018 through FY 2021. Beginning in FY 2022, the CCI payments were included in MiSACWIS.

    B. **Private Agency Foster Care (PAFC), Independent Living Plus (ILP), and Enhanced Foster Care (EFC) Administration Payments.** Beginning in FY 2018 (10/1/2017 forward), PAFC, ILP, and EFC administration payments in Kent County were no longer logged into MiSACWIS. For the purposes of the cost study, these expenditures are now captured on the WMPC Cost Report and associated Accruals Report, in the case of ILP and EFC Administration. The PAFC, ILP, and EFC administration payments are reported in the aggregate on the WMPC Cost Report. The information below maps out the method for assigning and incorporating these costs.

        (i) **PAFC Admin.** The total PAFC Administration expense is evenly allocated at the child level across all applicable days in the specified Service Descriptions in the appropriate Fiscal Year. PAFC Admin is applied in full on placement start date, and no PAFC Admin is applied on the end date of a placement.[18]

[16] For FY 2021, we identified children with multiple ID numbers in MiSACWIS and removed duplicates from the dataset. As a result, placement counts for the 5th annual report are slightly lower than previous reports.

[17] All accrued expenses added to each FY's expenditure totals were removed from the subsequent FY totals to avoid double counting.

[18] In FY 2018, total PAFC Admin was found in the quarterly WMPC Cost Report – WMPC tab, cell C62. FY 2018's total PAFC administrative expense was $15,051,799. The applicable Service Descriptions included in the PAFC Admin allocation were 1780 – General Foster Care, 1782 – General Independent Living, 1783 – Specialized Independent Living, and all CCI Placement Payments included in the WMPC Cost Report Residential Services tab. Since these payments are paid prospectively, there was no need to include accrual information.

(ii) **EFC Agency Premium Administration Payments.** The total EFC Agency Premium Administration expense incorporated in this Cost Study is taken in aggregate from the WMPC Cost Report and Accruals detail and is not allocated at the child level for the county-level analysis.[19]

(iii) **ILP Admin.** The total ILP Administration expense incorporated in this cost study is taken in aggregate from the WMPC Cost Report and Accruals detail and is not allocated at the child level for the county-level analysis.

(iv) **Other Purchased Services – Kids First.** Representing expenses made to secure available beds, these costs were captured on both the WMPC Cost Report and Accrual Detail. They were grouped under the Service Domain of Residential Services.[20] (See Appendix D for a full mapping of expenditures codes.)

C. **BP 515 Payment Workbook.** Spanning FY 2015 through FY 2017, these annual workbooks include the monthly BP 515 expenses—the administration costs for children's placements that traditionally would not have received an administrative rate (e.g., residential care, unlicensed relatives)—by agency and revenue source. These workbooks are used because during the baseline period (FYs 2015-2017), BP 515 costs were not recorded in MiSACWIS. In FY 2018 and afterward, these costs are included in the PAFC admin rate within the WMPC Actual Cost Reporting Workbook.

4. **Trial Reunification Payments.** Spanning FY 2015 through FY 2017, these trial reunification payments—administrative payments made to agencies during the time a child is on a trial home discharge—include detail at the agency and fiscal-year level. These payments are used because during the baseline period (FYs 2015-2017), trial reunification payments were not recorded in MiSACWIS. In FY 2018 and afterward, these costs are included in the PAFC admin rate within the WMPC Actual Cost Reporting Workbook.

The integration of these data sources into a comprehensive assessment of fiscal activity in Kent County is further detailed in the sections that follow, including the data collection and analysis sections.

2.3.3 Data Collection

The cost study team received fiscal and placement data for the period of 10/1/14 through 9/30/22 (FYs 2015-2022) for all counties in Michigan. However, as noted above, for this report, most of the analysis focuses on Kent County system-level expenditure and revenue trends. These fiscal and placement data are limited to those for which Kent County is recorded as having legal responsibility for the child and thus has responsibility for providing placement and other services to the child (and family).[21]

WMPC's five private partner agencies provide services to most—but not all—children for whom Kent County is responsible. Young adults in voluntary foster care (YAVFC) or who are involved with

[19] In FY 2018, total EFC Admin was found in the quarterly WMPC Cost Report – WMPC tab, cell C64 – and in the Accruals Detail report. FY 2018's total EFC administrative expense was $480,770.

[20] WMPC Cost Report – WMPC tab, cell C66.

[21] Each fiscal and placement record indicates a County of Responsibility and Removal County. For this report, we are focusing on the County of Responsibility.

the juvenile justice (JJ) system, youth[22] with out-of-state supervision (OTI), and unaccompanied refugee minors (URM) are not under WMPC's purview. The cost study team identified children that the private agencies served based on their WMPC program dates; their YAVFC, JJ, and OTI legal status; and a child-level indicator that they are not URM. Additionally, any expenditure associated with the URM Overall Funding Source was excluded. These child-level identifiers allow WMPC-related payments and placements to be analyzed separately from those served by Kent County, but not by WMPC's partner agencies. These parameters were also applied to the baseline period of FY 2015 through FY 2017 so that the fiscal activity in FY 2018 through FY 2022 could be compared with a similar population of children. To summarize, all expenditure, revenue, and placement data presented in the cost study exclude any records associated with a URM, YAVFC, JJ, or OTI case – both in the pre- and post-implementation periods. Table 2-1 summarizes key cost data elements and data sources. It is important to note that because WMPC began implementation of the Kent Model on 10/1/2017, some data sources vary across the two time periods (before and after implementation).

Table 2-1. Kent County fiscal data elements by data source

Data source	Pre-implementation (10/1/14 – 9/30/17)	Post-implementation (10/1/17 – 9/30/22)
MiSACWIS Payments	• Maintenance and administrative payments for out-of-home placement services • Includes all private agency administrative payments and all Child Caring Institution (CCI) payments	• Maintenance and administrative payments for non-CCI out-of-home placement services • Excludes private agency administrative payments and all CCI payments
WMPC Actual Cost Reporting Workbook		• CCI payments for children that the WMPC serviced • PAFC, ILP, and EFC administrative payments • Other purchased services (Kids First)
Other Fiscal Data	• BP 515 payments (administrative payments for CCI and other non-admin-paid living arrangements) • Trial reunification payments	• WMPC accruals (CCI, PAFC, ILP, & EFC Admin, Kids First)
MiSACWIS Child Placement Data	• Child placements, child demographics, removal information, worker information	• Child placements, child demographics, removal information, caseworker information

Building on the data in Table 2-1, the cost study team constructed a basic longitudinal database allowing for analysis of changes in expenditure and revenue patterns at the state and county levels, across Fiscal Years. The database further allows the flexibility to compare financial data within and across counties, across Fiscal Years, and within child welfare-specific expenditure and revenue categories. In this report, Kent County WMPC expenditure and revenue trends are presented for the baseline period (FYs 2015-2017) and 5 years post-implementation (FYs 2018-2022). The cost team also analyzed placement data to understand care-day utilization. This involved creating a "child event" file to summarize the number of care days used by state Fiscal Year, placement event, and provider type (e.g., foster care, kinship, congregate care, etc.). Findings from the cost study are presented in Chapter 3.

[22] The term "youth" is used to refer to children across the age continuum, from young children to older youth.

2.4 Outcome Study Methodology

Data presented in Section 3.2 reflects events and outcomes through September 30, 2022. PSM was used to generate a comparison group. The overall Kent County sample (n = 2,077) was matched with children who were associated with a private agency outside Kent County for at least 80 percent of their placement (n = 2,062). Children also were matched on demographic characteristics (i.e., race, ethnicity, gender, age) and the circumstances that prompted their entry into care (e.g., the type of abuse/neglect reported). The groups and subsequent tables are organized based on the official start date of the pilot (10/1/2017). The outcomes are presented separately for children who are associated with WMPC prior to the official start date (referred to as legacy cases, n = 763) and children who entered a WMPC placement on or after the official start date (n = 1,314) to allow year-by-year comparisons and tests for significance in addition to the full group comparisons.

After random control, PSM is the next most rigorous method for creating a comparison group in a study, allowing conclusions to be made on estimates of observed outcomes between the comparison and treatment groups. Using the PSM method for identifying the comparison group, the study team identified covariates for children in Kent County, and then sampled from a group of children who were in foster care at least 80 percent of the time and had statistically similar covariate representation (e.g., age, sex, removal year, allegation type, race, and ethnicity). For previous reports, the matched group for children entering care after 10/01/2017 were created using propensity scores from the entire cohort of children in Kent County who entered care after 10/01/2017, using the entry year as one of the PSM elements. For this report, propensity score matched groups for children entering care after 10/01/2017 were made separately for each entry year.

For the purpose of this outcome study, the definition of out-of-home placement spells aligns with the definition used for the cost study (the time in care between date of removal and date of discharge with a few exceptions). Children whose out-of-home placement included only parental home placement types during their time under state supervision are excluded from both the Kent County and comparison groups. For children who have additional or other out-of-home placement types (besides parental home placement types), the date of removal is used as the beginning of their out-of-home placement spell. The end of a child's out-of-home placement spell is the date of discharge from care, unless the child was discharged to reunification, their last recorded placement was "parental home," *and* the child had been at that placement for at least 30 days. For these children, the start of parental home placement is used as the date for the end of a child's out-of-home placement spell.

2.5 Process Study Methodology

This section provides an overview of the evaluation team's methods for collecting process evaluation data.

2.5.1 Data Collection

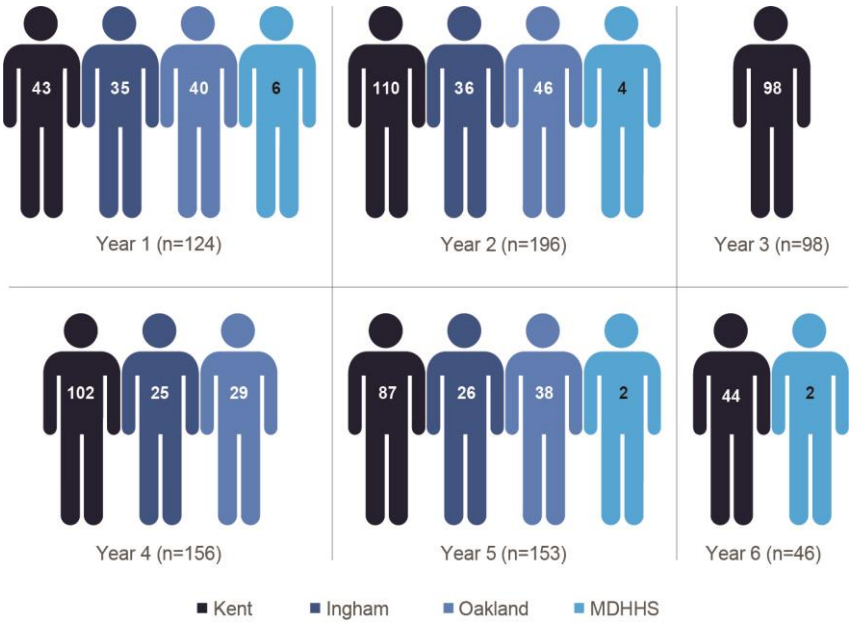
The evaluation team collected data for the process study each year between 2017 (in September, prior to Kent County's October 1 implementation launch date) and 2021. During these periods, the study team collected qualitative data on topics aligned with the guiding principles for child welfare practice in Michigan: Kent Model implementation, case planning and case practice, services provided to families, monitoring and accountability, interagency collaboration, and challenges and facilitators. The team conducted interviews and focus groups with public child welfare and private agency leadership and samples of supervisors and caseworkers across the child welfare system

continuum (i.e., Child Protective Services investigation and ongoing casework, foster care case management, and adoption services). Interviews were also conducted with representatives from MDHHS, county court systems and mental health agencies, and WMPC. For Kent County in particular, 5 years of data on implementation of the Kent Model facilitated interpretation of the model's effect on public and private child welfare agencies and key community partners (i.e., mental health, court, county administrators), as well as how implementation evolved over time.

The study team collected the last round of data in May 2022. This final round of interviews and focus groups explored participants' perceptions of and experiences with the Kent Model at the end of the pilot period. The pool of respondents was limited to Kent County DHHS and private agency leaders and supervisors, and WMPC leadership who have worked at their respective agency since 2017 (when the Kent Model launched). The process study team also conducted interviews with MDHHS leaders. Participants responded to questions about their perceptions of Kent Model effectiveness, expectations for inter- and intra-agency collaboration after the pilot ends, and lessons learned.

The total number of agency staff and partners who participated in interviews and focus groups each year of the evaluation is provided in Exhibit 2-1.

Exhibit 2-1. Number of interview and focus group respondents by county/agency and year



Note: Year 1 is the baseline period (prior to the launch of the Kent Model).

Throughout pilot implementation, members of the evaluation team also observed meetings (via telephone and web conferencing platforms), including the Child Welfare Partnership Council, the Kent County Directors Steering Committee, and the WMPC Advisory Committee.

Through the process evaluation, the study team *describes* child welfare services in terms of "how" and "why" rather than "what" (e.g., specific outcomes the services produce). In addition, this approach allows for the consideration of the context in which child welfare services are being supported and implemented across the three counties. In Michigan, as in most states, child welfare

practice is fundamentally rooted in Federal and state law, agency policies and procedures, and to a large extent, in how those are operationalized and implemented at the agency level. As such, it is imperative to study child welfare practice within the context in which it occurs; it is not appropriate to assume that all agencies understand and implement state policies and practices in the same way or experience the same facilitators and challenges to doing so. Reliance on interviews and focus groups as the primary source of data helps ensure opportunities exist to obtain multiple perspectives to inform research questions (and activities of interest), resulting in a more comprehensive and multilevel understanding of child welfare practice in each county. It also allows for similarities and differences across the agencies/counties to be uncovered and examined. Process evaluation findings also are used to understand child welfare practice and provide context in which outcomes and costs are evaluated and understood.

3. Child Welfare Cost, Outcome, and Process Results

3.1 Cost Study: Expenditures, Revenue, and Average Daily Unit Cost

3.1.1 Data Analysis

The outcomes examined and reported here focus on the expenditure and revenue trends in Kent County. The period examined is split between the baseline years (FYs 2015-2017)—the 3 years prior to the implementation of the Kent Model—and the first 5 years post-implementation (FYs 2018-2022). An adjustment for inflation has been made to allow comparability of expenditures across years. All expenditures, unless otherwise noted, have been adjusted to constant dollars using FY 2022 dollars as the base year and adjusting previous years' expenditures by the Consumer Price Index (CPI).[23]

The expenditures and revenue presented in this report are for all children and families who received out-of-home placement services in Kent County under WMPC and all children and families during the baseline period who belonged to a population served by WMPC's private partner agencies. The designations of these WMPC-related costs differ by period:

- **Baseline Period (FY 2015 through FY 2017).** During the 3 years prior to the implementation of the Kent Model, expenses, revenues, and placement days were only included in the cost study's data analysis if they belonged to a child or youth who was not associated with a URM, YAVFC, JJ, or OTI status.

- **Post-Implementation Period (FY 2018 through FY 2022).** During the first 2 years of the Kent Model, costs and revenue were limited to those WMPC reported. Placement days examined during this period were again limited to those that belonged to a child or youth who was not associated with a URM, YAVFC, JJ, or OTI status.

The key outcomes examined for this report were:

1. **Annual Expenditures by Service Type.** For this analysis, annual expenditure levels within Kent County from FY 2015 through FY 2022 are compared to examine changes in expenditures by service types (Service Domain).

2. **Annual Placement Maintenance Expenditures.** This report breaks down placement expenditures into two major categories—Administration and Maintenance. Maintenance expenditures reflect the payments for the daily care and supervision of children in out-of-home care. For CCI placements, maintenance costs also include the provision of social services and clinical treatment. Administration expenditures represent the costs to manage

[23] United States Department of Labor (2022). Constant costs are calculated using the following equation: Current Year Real Cost = (Base Year CPI/Current Year CPI)*Current Year Nominal Cost. All constant costs are converted into FY 2021 dollars, so the Base Year is FY 2021. The CPI for FY 2021 is calculated by taking the average CPI of the monthly CPIs for the period October 2020 through September 2021 (266.616).

child placement services and administrative costs related to foster care for children.[24] For this analysis, we include an in-depth look at shifting expenditures by placement setting maintenance expenditures.

3. **Annual Revenue by Funding Source.** For this analysis, annual WMPC-related revenue totals within Kent County from FY 2015 through FY 2022 are compared to examine changes in revenue by funding source.

4. **Placement Days.** Care-day utilization is examined by state Fiscal Year and placement type to determine whether the volume of care days and per unit costs of care have changed under the Kent Model (as compared to the baseline period).

5. **Average Daily Unit Cost of Care.** To examine annual trends in the average daily unit cost of care, total annual placement costs are divided by annual placement days and trend analyses are run.

Findings for these key outcomes are presented in the sections that follow.

3.1.1.1 Expenditures Trends

Research Question: What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?

The tables and figures in this section present expenditure totals by Fiscal Year and service domain where Kent County is the county responsible for payment. All dollar amounts are presented in thousands and adjusted for inflation. Payments for substance abuse services, treatment services (which include services such as domestic violence counseling, parental education, and a family reunification program), and consortium case/capitated rates are excluded.[25] Table 3-1 presents all Kent County expenditures (excluding URM, YAVFC, JJ, and OTI), with expenditures broken down by Service Domain. All subsequent tables and figures present data that excludes all payments related to YAVFC, OTI, JJ, and URM cases.

[24] In the baseline period, FY 2015 through FY 2017, the administration expenditures for non-CCI placements are captured in the ADMIN_AMOUNT variable in the MiSACWIS data. For CCI placements during this period, their administration expenditures are captured in the BP515 report while their ADMIN_AMOUNT in MiSACWIS is included in the CCI's maintenance expenditures. All placement administration expenditures are captured in the WMPC Cost Report or Accruals Detail in FY 2018 and beyond.

[25] Substance abuse expenditures are excluded due to the inconsistent recording of these services in the data from year to year. Treatment services are excluded because they only begin to appear in the data in FY 2018 (despite the services themselves being offered prior to that year).

Table 3-1. Kent County[26] – Expenditures in thousands of dollars, by Fiscal Year, service domain, and URM/YAVFC/JJ/OTI status, adjusted for inflation								
Service domain	**Pre-implementation**			**Post-implementation**				
	FY 2015	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
Total Kent County expenditures	$35,655	$38,187	$44,202	$51,219	$51,626	$45,572	$36,201	$29,015
Total private agency expenditures (excluding URM, YAVFC, JJ, & OTI)	$27,267	$27,104	$30,481	$36,515	$38,196	$31,219	$23,642	$19,528
Placement – Maintenance[27]	$12,832	$13,867	$16,498	$17,632	$17,691	$16,511	$12,107	$9,148
Placement – Administrative[28]	$13,214	$12,198	$13,481	$17,969	$19,843	$13,819	$11,059	$9,604
FC Placement Service	$934	$837	$216	$213	$245	$258	$273	$182
Residential Services	$112	$47	$134	$545	$259	$533	$99	$48
Mental Health	$139	$138	$122	$139	$124	$44	$31	$25
Physical Health	$8	$15	$20	$9	$15	$9	$6	$7
Independent Living	$0	$1	$1	$4	$13	$34	$65	$46
Education	$13	$1	$10	$4	$7	$12	$1	$2
Adult FC Service	$15	$0	$0	$0	$0	$0	$0	$466[29]
URM, YAVFC, JJ, or OTI expenditures	$8,388	$11,082	$13,721	$14,704	$13,430	$14,352	$12,559	$9,487

Overall, total out-of-home private agency expenditures increased in Kent County from FY 2016 through FY 2019 and decreased in FYs 2020 through 2022. In the baseline period, from FY 2015 to FY 2017, total private agency expenditures (excluding URM, YAVFC, JJ, and OTI) increased by 12 percent, with the largest annual increase during the baseline period occurring from FY 2016 to FY 2017 when total expenditures increased by $3 million in the year immediately preceding implementation of the Kent Model (a 12% increase). Another large growth in private agency expenditures (20%) occurred from FY 2017 to FY 2018—the first year of the post-implementation period. However, in FY 2019 there was a slight expenditure increase, with a 5 percent escalation of private agency expenditures from FY 2018 to FY 2019. There was an annual decrease of 18 percent in total child welfare expenditures in FY 2020, followed by a 24 percent decrease in FY 2021 and a 17 percent decrease in FY 2022. As the report presents later, these decreases in FY 2020 through

[26] Kent County expenditures here represent all expenditures for which Kent County is listed as the Responsible County.

[27] Maintenance expenditures reflect the payments for the daily care and supervision of children in out-of-home care. For CCI placements, maintenance costs also include the provision of social services and clinical treatment. Administration expenditures represent the costs to manage child placement services and administrative costs related to foster care for children.

[28] Administrative expenses reported are related to private agency payments, and do not include WMPC's $2 million administrative allocation.

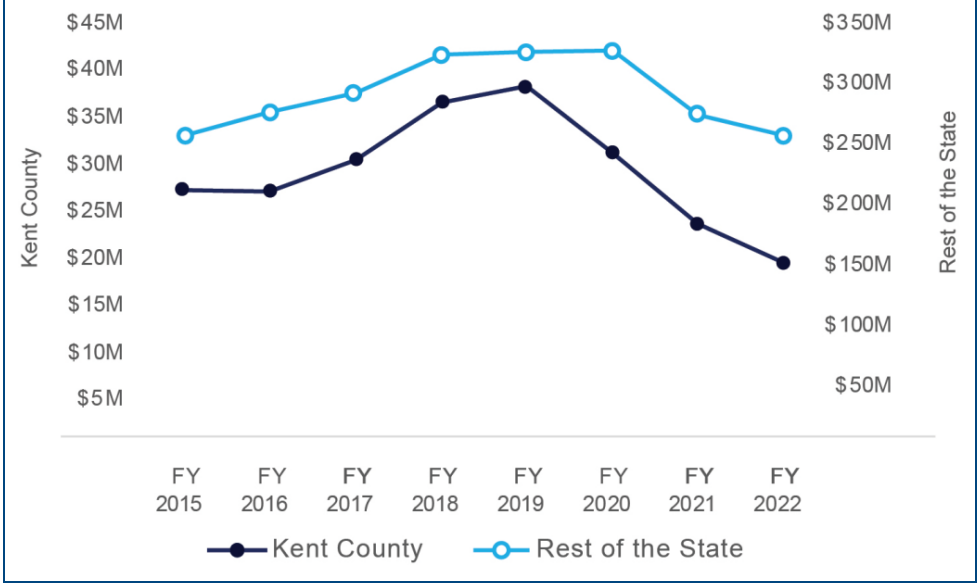
[29] During FY 2022, adult foster care services were added in Kent County.

FY 2022 expenditures are due in large part to a decline in admissions to care that began in FY 2019 and escalated during the COVID-19 pandemic.

Research Question: How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?

Figure 3-1 lays the costs trajectory in Kent County atop that in the rest of the state (all public and private agencies) to enable comparison of the trend lines despite the differences in volume of total costs. During the baseline period, the rest of the state saw a 14 percent increase while Kent County saw theirs increase by 12 percent. However, during the pilot period, the rest of the state saw total child welfare expenditures plateau between FY 2018 and FY 2020 while Kent County's expenditures increased slightly in FY 2019 and then dropped in FY 2020. In FY 2021 and FY 2022, expenditures declined more rapidly in Kent County than across the rest of the state.

Figure 3-1. Kent County and the rest of the state – Total child welfare expenditure trends by Fiscal Year, adjusted for inflation



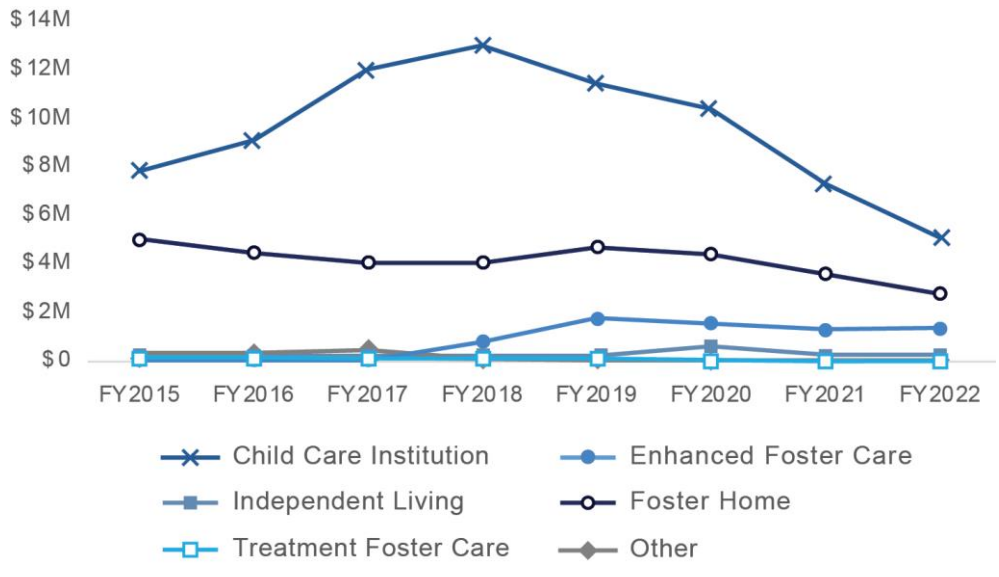
In Kent County, placement maintenance and placement administrative expenses make up 97 percent of the total private agency expenditures, so the expenditure trends described above are driven by these placement costs. Placement maintenance costs include the daily maintenance rate paid for a child's placement, and placement administrative costs include the daily administrative rate paid to agencies for a child's placement. Placement maintenance and administrative expenses increased from FY 2017 to FY 2018 by 7 percent and 33 percent, respectively. FY 2019 saw a 10 percent change in placement administrative expenditures, and placement maintenance expenditures stayed steady. FY 2020 saw a reduction in both maintenance and administrative costs with placement maintenance costs dropping 7 percent and placement administrative costs reducing by nearly one third (30%). Reductions continued through FY 2021, with a 27 percent decrease in maintenance costs and a 20 percent decrease in administrative costs, and through FY 2022, with a 24 percent decrease in maintenance costs and a 13 percent decrease in administrative costs. The reduction in placement costs in FY 2020 through FY 2022 was due to a decrease in the number of care days provided and a reduction in the administrative per diem rate. We will explore both fiscal drivers (i.e., the quantity and price of care) in upcoming sections. For a full mapping of

Service Domains to all relevant Service Categories and Service Descriptions, please refer to Appendix D.

To understand the trend in increasing costs, it is also necessary to break out placement costs by placement setting.

As shown in Table 3-1, placement maintenance expenditures increased each year from FY 2016 through FY 2019, growing by 29 percent during the baseline period and an additional 7 percent in the first year of post-implementation. As seen in Figure 3-2, increases in CCI placement maintenance expenditures fueled the overall trend during this period and began in the baseline period, with these costs increasing by 54 percent from FY 2015 to FY 2017. This trend continued into the first year following implementation—although at a reduced rate—with CCI maintenance costs increasing 7 percent from FY 2017 to FY 2018. Not only did CCI maintenance expenses increase in total, but they also grew in proportion. In FY 2015, CCI maintenance costs made up 60 percent of all placement maintenance costs, but in FY 2018, that proportion had grown to 72 percent. The proportion spent on CCI decreased to 63 percent of maintenance costs in FY 2019 as EFC—which is intended as an alternative to CCI—increased to 10 percent of costs. The proportion spent on CCI further decreased to 54 percent of expenditures in FY 2022 while EFC rose to 14 percent.

Figure 3-2. WMPC-related – Placement maintenance expenditure trends by placement setting, adjusted for inflation

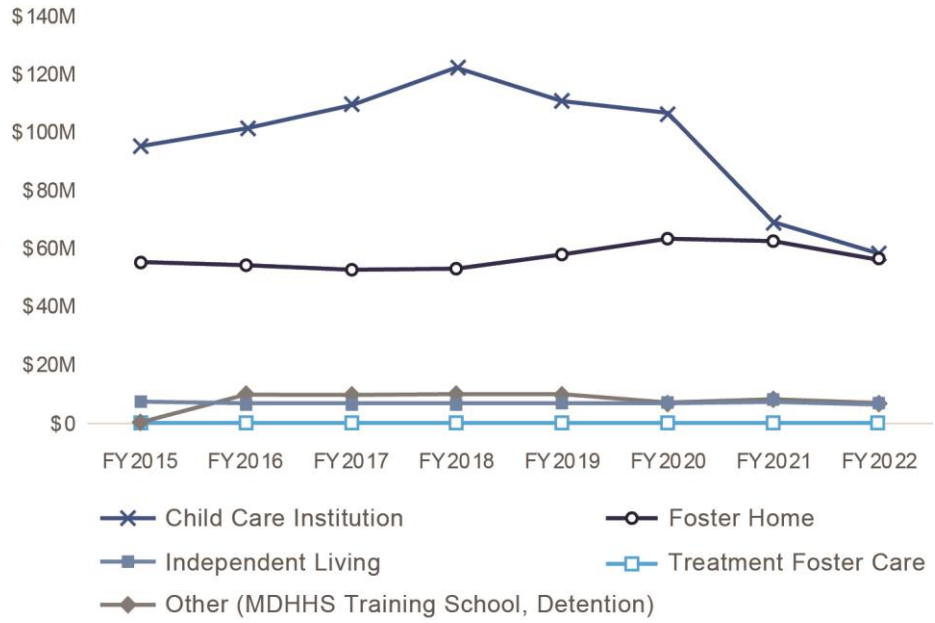


Although foster care and EFC maintenance expenditures grew during FY 2019 (by 16% and 130%, respectively), CCI maintenance payments decreased at such a rate (12%) to counteract those fiscal effects. FY 2020's drop in maintenance expenditures was seen in all major placement settings, including Foster Home, CCI, and EFC with each category decreasing by 7 to 13 percent. Reductions in major placement setting expenditures continued in FY 2021, with decreases of between 17 and 30 percent, and again in FY 2022, with decreases of 30 percent for CCI maintenance payments and 23 percent for foster homes.

Looking at maintenance expenditures by placement setting in the rest of the state shows some similar trends in CCI placements (Figure 3-3). CCI maintenance costs make up the majority of the

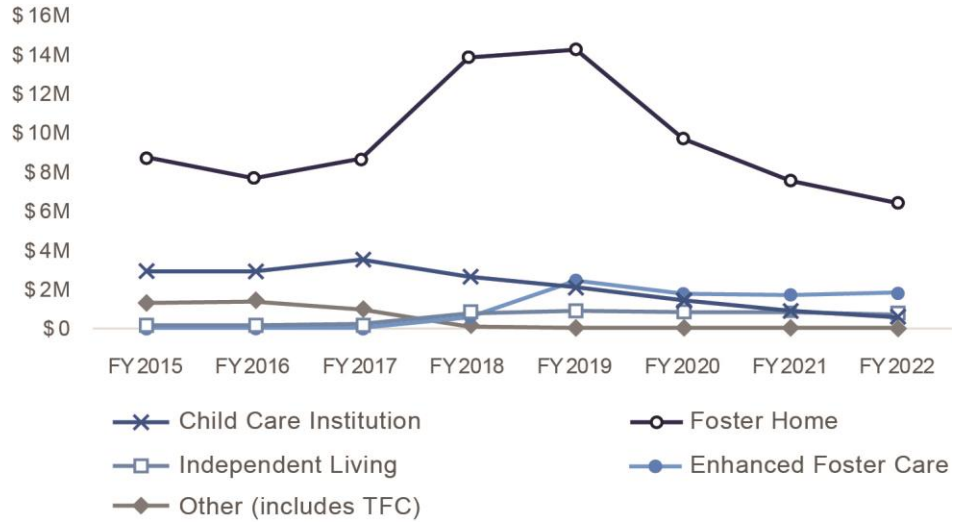
costs in the rest of the state, and peak in FY 2018, just as in Kent County. The rest of the state also saw a decline in CCI maintenance costs between FY 2019 and FY 2022, for a total decrease of 52 percent from FY 2018 levels. However, the rate of decline in CCI costs was steeper in Kent County during the same period, with a 61 percent decrease. In the rest of the state, CCI care days (and consequently, costs) decreased significantly between FY 2020 and FY 2021; care days in FY 2021 totaled 65 percent of the care day count in FY 2020. During this period, unit costs also decreased slightly, contributing to further reductions in maintenance expenditures. The same decline was not true of foster homes. Although there was a decrease in the number of care days, in FY 2021, the total was about 93 percent of the count from FY 2020. During this period, unit costs also increased slightly, contributing to the closing of the expenditure difference attributable to the decrease in care days.

Figure 3-3. Rest of the state – Placement maintenance expenditure trends by placement setting, adjusted for inflation



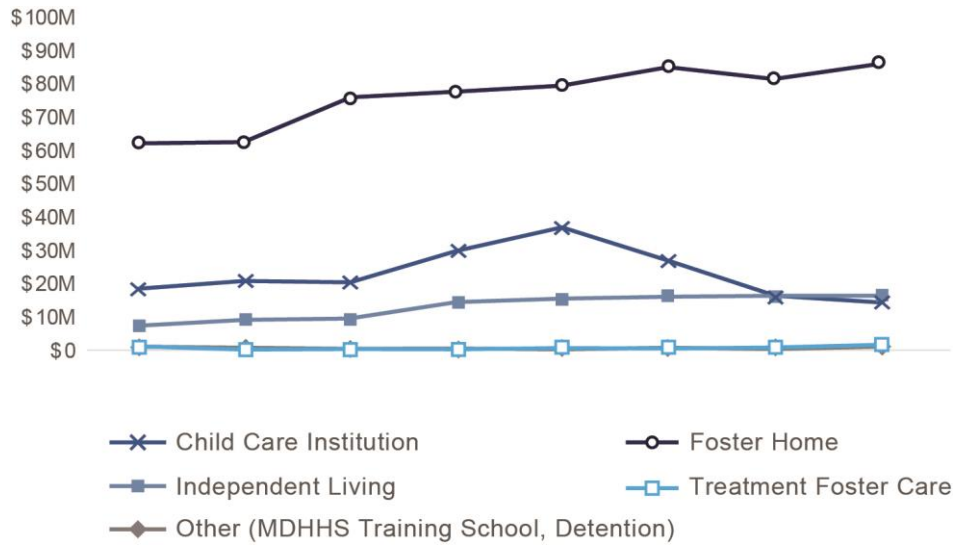
Looking at placement administrative costs, there is a slightly different picture. The rise in placement administrative expenditures since FY 2016 has been attributable primarily to administrative costs associated with foster home placements, and from FY 2018 through FY 2022, EFC placements as well (Figure 3-4). The largest increase came in the first year of post-implementation (FY 2018) when foster home and kinship care placement administrative costs rose by 60 percent. The impact of the reduction in placement administrative expenditures in FY 2020 through FY 2022 was spread across Foster Home, CCI, and EFC administration costs, with each category decreasing by 25 to 74 percent between FY 2020 and 2022.

Figure 3-4. WMPC-related – Placement administrative expenditure trends by placement setting, adjusted for inflation



Placement administration expenses in the rest of the state showed much less variability, particularly in the Foster Home category (Figure 3-5). Foster Home administration costs stayed more stable, increasing slightly each year from FY 2017 through FY 2020, and dipping slightly in FY 2021 before increasing again during FY 2022. CCI administration costs increased in FY 2018 and FY 2019 but was followed by steady reductions in FYs 2020 and 2021 and a flatter reduction during FY 2022.

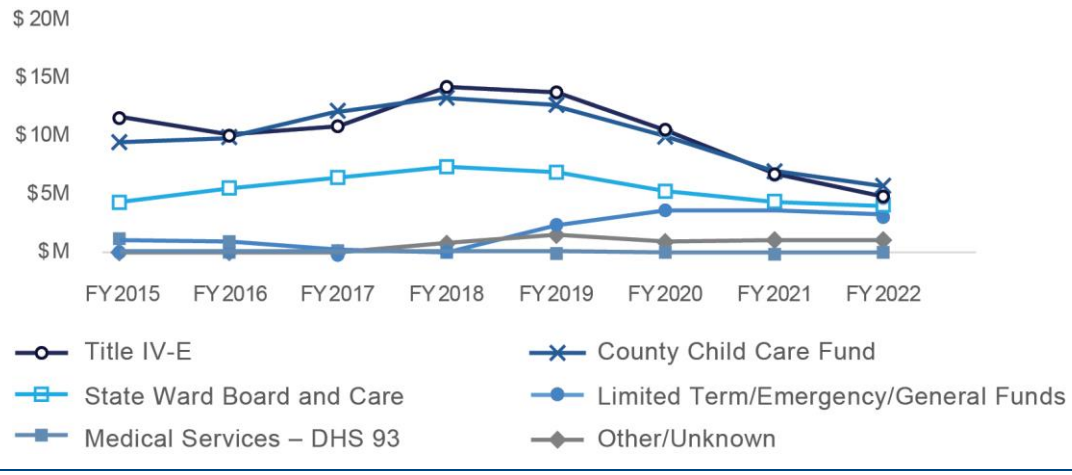
Figure 3-5. Rest of the state – Placement administrative expenditure trends by placement setting, adjusted for inflation



3.1.1.2 Revenue Trends

As shown in Figure 3-6 and Table 3-2, the two largest funding sources for out-of-home placement services are the Federal Title IV-E funds and the County Child Care Fund. Total Title IV-E revenue used each year remained fairly constant until an increase in FY 2018. The proportion of revenue attributable to this funding category declined in the baseline period—from 43 percent in FY 2015 to 36 percent in FY 2017. In FY 2018, Title IV-E revenue increased to make up 39 percent of total revenue, but between FY 2019 and FY 2022, this revenue source decreased in amount and proportion. The same was true of the County Child Care Fund. During this same period, the amounts of other funding sources fluctuated, but they each increased as a *proportion* of Kent County revenue. For example, beginning in FY 2020, Limited Term/Emergency/General Funds grew to make up 12 percent (FY 2020), 15 percent (FY 2021), and 17 percent (FY 2022) of the revenue used to support child welfare activities in Kent County.

Figure 3-6. WMPC-related – Revenue totals by overall funding source and Fiscal Year, adjusted for inflation [30,31,32]



The rest of the state receives the majority of revenue from Title IV-E, the County Child Care Fund, and State Ward Board and Care (see Table 3-3). Revenue from Title IV-E has declined recently for the rest of the state, from 42 percent of total revenue in FY 2019 to 29 percent in FY 2022. Similarly, Title IV-E funds account for a smaller proportion of Kent County's revenue in FY 2022. The rest of the state has a lower proportion of revenue from the County Child Care Fund compared to Kent County. For example, in FY 2022, Kent County received 32 percent of total revenue from this source compared to 19 percent in the rest of the state. The opposite is true of Limited Term/Emergency/ General Fund revenue; in FY 2022, Kent County received 17 percent of total revenue from this source compared to 25 percent for the rest of the state.

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[30] All pre-implementation revenue is determined by the OVERALL_FUND_SOURCE in MiSACWIS.

[31] Most revenue in the post-implementation period is determined by the OVERALL_FUND_SOURCE in MiSACWIS or the revenue detail on the Residential Services tab in the WMPC Cost Report for the CCI placement expenditures. However, revenue associated with the aggregate EFC Admin costs was not available and was instead estimated by assigning revenue types to the EFC Admin expense based on the revenue type split in the pre-implementation period.

[32] Other/Unknown revenue includes Temporary Assistance for Needy Families and Youth in Transition revenue and the revenue associated with Kids First expenditures.

Table 3-2. WMPC-related – Revenue proportions by overall fund source and Fiscal Year								
Overall fund source	Pre-implementation			Post-implementation				
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Total private agency revenue (excluding URM, YAVFC, JJ, and OTI)	100%	100%	100%	100%	100%	100%	100%	100%
Title IV-E	43%	38%	36%	39%	36%	34%	29%	25%
County Child Care Fund	37%	38%	41%	38%	35%	34%	32%	32%
State Ward Board and Care	16%	20%	21%	20%	18%	17%	19%	21%
Limited Term/Emergency/ General Funds	4%	4%	1%	0%	6%	12%	15%	17%
Medical Services – DHS 93	1%	1%	0%	0%	0%	0%	0%	0%
Other/Unknown[23]	0%	0%	0%	2%	4%	3%	5%	6%

Table 3-3. Rest of the state – Revenue proportions by overall fund source and Fiscal Year								
Overall fund source	Pre-implementation			Post-implementation				
	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Total revenue (excluding URM, YAVFC, JJ, and OTI)	100%	100%	100%	100%	100%	100%	100%	100%
Title IV-E	45%	41%	44%	43%	42%	37%	31%	29%
County Child Care Fund	24%	25%	25%	26%	24%	23%	21%	19%
State Ward Board and Care	25%	29%	28%	27%	26%	23%	23%	25%
Limited Term/Emergency/ General Funds	4%	3%	1%	1%	6%	16%	22%	25%
Medical Services – DHS 93	1%	1%	1%	1%	1%	1%	1%	1%
Other/Unknown[23]	1%	1%	1%	1%	1%	1%	1%	1%

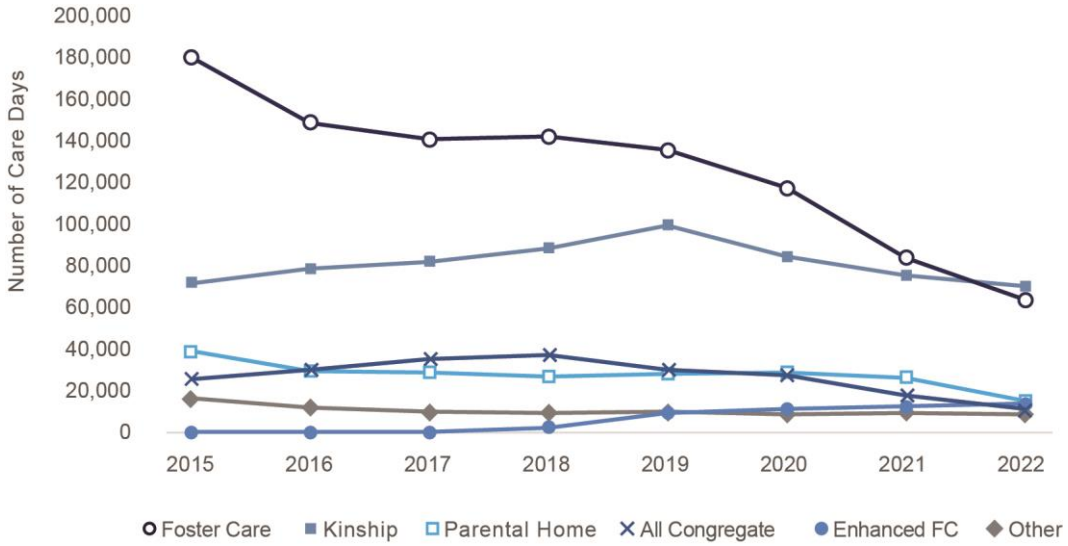
3.1.1.3 Care Day Utilization

Table 3-4 and Figure 3-7 show WMPC-related care-day utilization observed during the 3-year baseline period (FYs 2015-2017), and for the four most recent Fiscal Years under WMPC (FYs 2018-2022). As shown, care-day utilization increased slightly in FY 2018 and again in FY 2019, compared to the 3 years prior to WMPC implementation. Care days decreased between FY 2019 and FY 2020 and continued to decline substantially in FYs 2021 and 2022. In FY 2022, care days declined 19 percent from 2021 levels, from 224,513 total days to 182,698 days. Emergency shelter and parental home placements showed the largest percent decrease in care days when comparing FY 2021 to FY 2022, decreasing by 53 percent and 42 percent, respectively. The large declines in emergency shelter use in the past 2 years correspond to the closure of the Kids First emergency shelter. The largest portion of the drop came from decreased foster care utilization, which declined by approximately 20,000 days between FY 2021 and FY 2022.

Table 3-4. Kent County care days by state Fiscal Year and living arrangement (excluding URM, YAVFC, JJ, and OTI)

Placement setting	Pre-implementation			Post-implementation				
	2015	2016	2017	2018	2019	2020	2021	2022
Total Care Days	332,699	297,810	296,297	305,400	312,068	278,276	224,513	182,698
Foster Care	178,408	146,958	139,131	140,803	135,854	118,816	83,725	63,814
Kinship	71,401	78,331	82,039	88,166	98,987	83,569	75,396	70,475
Parental Home	38,986	29,667	28,989	26,649	27,967	28,586	26,237	15,163
Congregate	22,169	26,949	31,208	32,741	26,775	24,879	15,784	9,856
Independent Living	6,271	5,041	3,386	4,359	5,260	5,457	5,274	5,063
Emergency Shelter	1,688	1,861	3,311	3,109	2,829	1,957	635	300
Runaway	2,390	3,114	3,605	2,808	2,449	2,117	1,597	1,052
Enhanced FC				2,366	9,192	11,127	12,289	13,705
Adoptive Home	6,738	2,578	936	1,547	1,058	50	279	395
Detention	1,812	1,246	642	1,156	595	682	1,334	836
Treatment FC	2,142	1,524	1,677	923			46	
Hospital	694	541	1,373	773	1,102	1,036	1,917	2,039
Total Year-Over-Year Change		-10%	-1%	3%	2%	-11%	-19%	-19%
Foster Care		-18%	-5%	1%	-4%	-13%	-30%	-24%
Kinship		10%	5%	7%	12%	-16%	-10%	-7%
Parental Home		-24%	-2%	-8%	5%	2%	-8%	-42%
Congregate		22%	16%	5%	-18%	-7%	-37%	-38%
Independent Living		-20%	-33%	29%	21%	4%	-3%	-4%
Emergency Shelter		10%	78%	-6%	-9%	-31%	-68%	-53%
Runaway		30%	16%	-22%	-13%	-14%	-25%	-34%
Enhanced FC					289%	21%	10%	12%
Adoptive Home		-62%	-64%	65%	-32%	-95%	458%	42%
Detention		-31%	-48%	80%	-49%	15%	96%	-37%
Treatment FC		-29%	10%	-45%				
Hospital		-22%	154%	-44%	43%	-6%	85%	6%

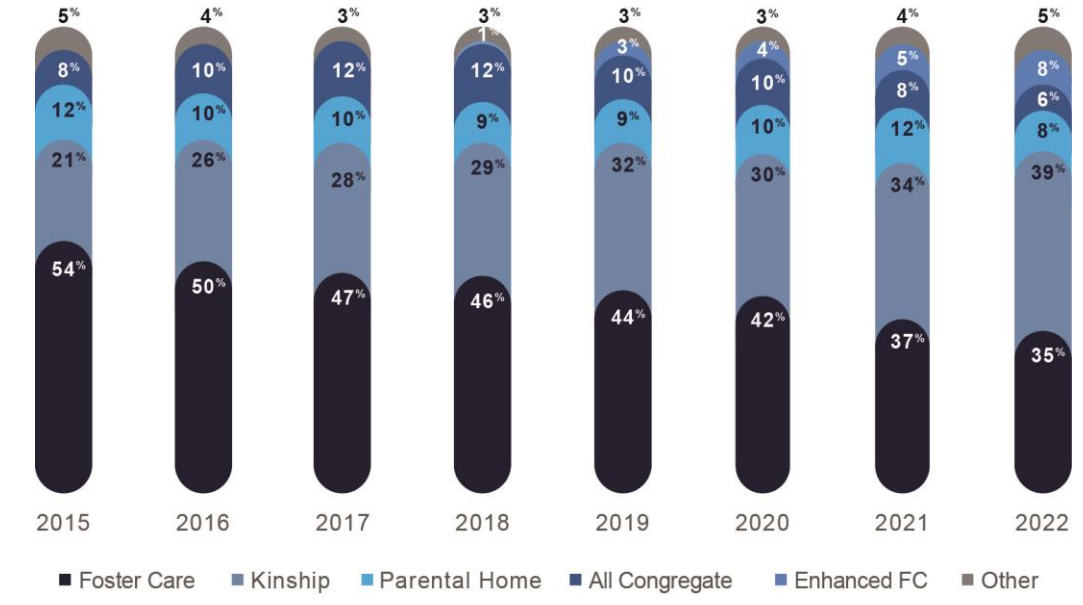
Figure 3-7. Kent County care-day utilization by state Fiscal Year and placement setting



Note: "All Congregate" includes congregate care, emergency shelter, and detention. "Other" placement setting includes hospital, out-of-state placement, and runaway service facility.

Care day utilization by placement type has shifted during the pilot. In the pre-pilot period (FYs 2015-2017), approximately half of care days were spent in foster care, 10 percent in congregate care, and one quarter in kinship care (see Figure 3-8). Since the pilot began in 2018, the proportion of care days spent in kinship care has gradually been increasing while foster care has decreased. This change may be attributable to WMPC's policy decision to implement paid kinship care. The proportion of days spent in congregate care remained at pre-pilot levels the first 3 years under WMPC (FYs 2018-2020), but has declined in the most recent 2 years (FYs 2021-2022). When the pilot began in FY 2018, 12 percent of care days were spent in congregate care compared to 6 percent in FY 2022. At the same time, the proportion of days spent in WMPC's EFC program, which is intended to reduce reliance on congregate care, has increased steadily from 1 percent of care days in FY 2018 to 8 percent in FY 2022.

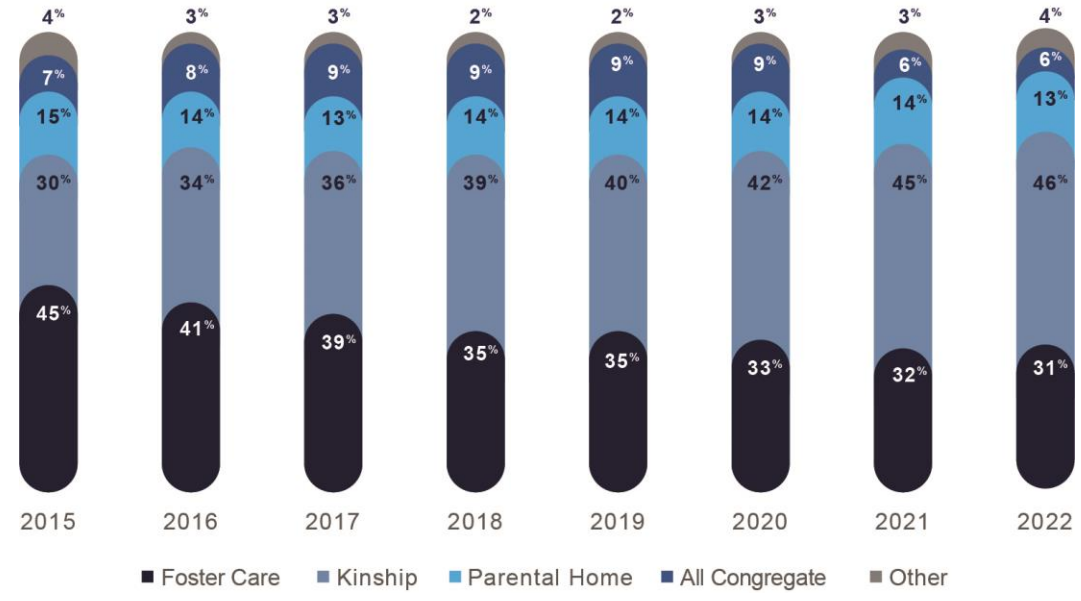
Figure 3-8. Kent County care-day utilization by state Fiscal Year and placement setting as a percentage of total care days



Note: "All Congregate" includes congregate care, emergency shelter, and detention. "Other" placement setting includes hospital, out-of-state placement, and runaway service facility.

Figure 3-9 shows care-day utilization for the rest of the state as a percentage of total annual care days. Like Kent County, the rest of the state has consistently used the majority of care days in the least costly foster care and kinship care settings. However, Kent's utilization of more expensive care types, namely congregate and enhanced foster care, is slightly higher than the rest of the state. While Kent has decreased their use of congregate care during the pilot compared to pre-pilot, it was higher than in the rest of the state for the first 4 years of the pilot (FYs 2018-2021). In FY 2021, for example, 8 percent of Kent County's total care day utilization was in congregate settings compared to 6 percent in the rest of the state. However, in FY 2022, 6 percent of care days were spent in congregate settings for both Kent County and the rest of the state. Kent County's use of EFC, which is intended to reduce reliance on congregate care, has also increased gradually during the pilot. Kinship care utilization increased in both Kent County and the rest of the state during the pilot, but the rest of the state has a larger portion of days spent in kinship care.

Figure 3-9. Rest of the state care-day utilization by state Fiscal Year and placement setting as a percentage of total care days



Note: "All Congregate" includes congregate care, emergency shelter, and detention. "Other" placement setting includes hospital, out-of-state placement, and runaway service facility.

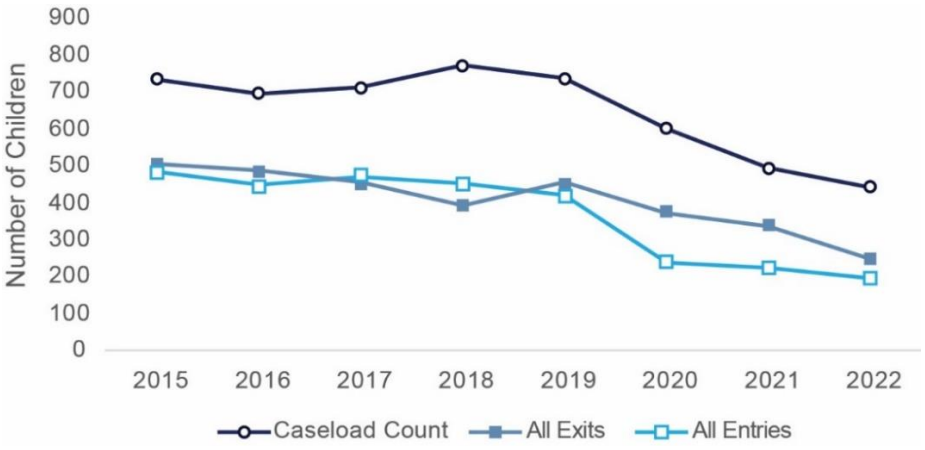
To understand shifts in out-of-home placement days and their related costs, expenditure structure must be examined. Total out-of-home placement expenditures are influenced by two components: (1) price of care and (2) quantity of care days; that is, how much a child welfare system spends on out-of-home placements (expenditures) is a function of how much that collection of services costs per day (price) and the number of care days for which it is provided (quantity).

*Placement Expenditures = Price * Quantity*

In short, a change in the average cost per care day or in the number of care days would affect total out-of-home expenditures. The number of days in care is affected by the number of children entering care and how long they stay in care.

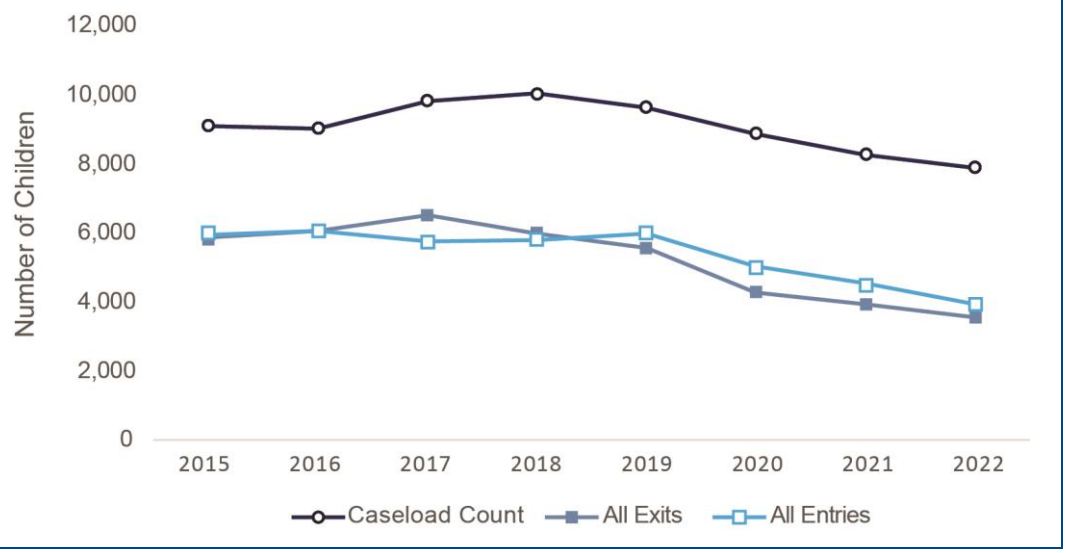
Historic child entries, exits, and a point-in-time caseload count at the end of the Fiscal Year are measured to determine how changes in care-day utilization over time correspond to the volume of children moving in and out of care (see Figure 3-10). Child entries include all children entering care for the first time during the year, or re-entering care for a new placement spell. Exits include all discharges from out-of-home care, and the caseload count represents the number of children in care on the last day of the Fiscal Year. Similar to the change in total care days, the number of child entries was fairly stable during the baseline period and into FY 2018, declined slightly in FY 2019, then declined more dramatically in FY 2020, and continued to drop in FY 2021 and FY 2022. In FY 2020, there was a 43 percent drop in the number of children entering care compared to FY 2019, and child entries continued to decline in 2021 and dropped 13 percent in FY 2022 compared to FY 2021. Child exits and the caseload count also declined in FY 2020 through FY 2022 compared to previous years. In FY 2022, the caseload count declined by 10 percent, relative to FY 2021, and exits dropped by 27 percent.

Figure 3-10. Kent County child entries, exits, and caseload count at the end of the Fiscal Year



The number of children entering, exiting, and in care (i.e., the caseload count) in the rest of the state followed the same overall trend as Kent County with a decline between FY 2019 and 2022 (see Figure 3-11). However, the decline in the rest of the state was not as substantial as it was for Kent County between FY 2019 and FY 2020—child entries decreased by 43 percent in Kent County from FY 2019 to FY 2020, compared to a 23 percent decline in the rest of the state. Between FY 2021 to FY 2022, child admissions declined by about 10 percent, the caseload dropped 5 percent, and exits decreased by 14 percent in the rest of the state. While the rest of the state experienced declines on entries, exits, and the caseload from 2021 to 2022, Kent County saw larger decreases. Most notably, child exits in Kent County decreased 27 percent from FY 2021 to 2022, compared to a 14 percent decrease in the rest of the state. The decrease in exits for Kent County in FY 2022 may be explained by longer durations in care for children entering care in FY 2021 (see Table 3-5 and Figure 3-12).

Figure 3-11. Rest of the state child entries, exits, and caseload count at the end of the Fiscal Year



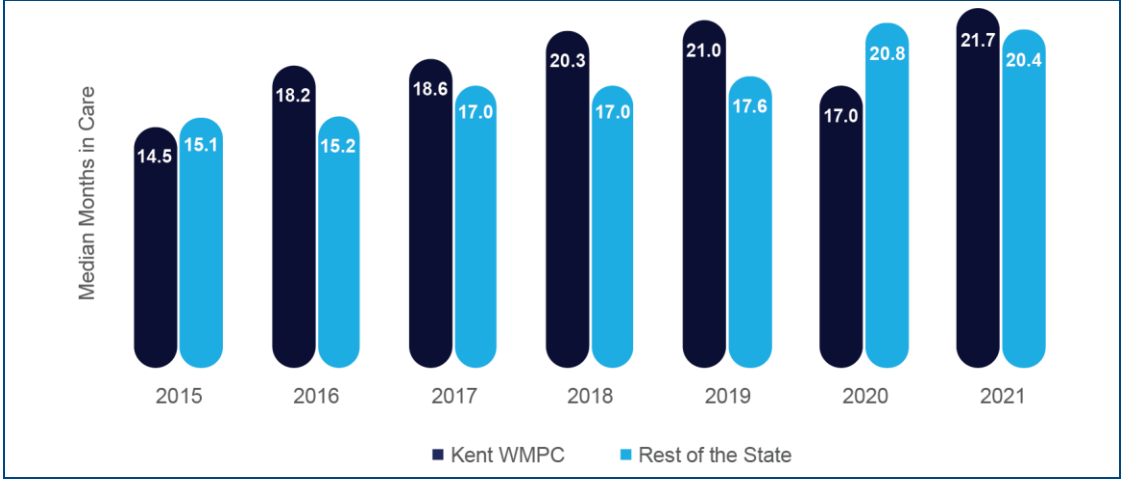
The volume of care days provided is also a function of how many days children stay in care. Duration in care was measured for entry cohorts using survival analysis. Table 3-5 shows that for all children entering care in Kent County in FY 2021, it took 10 months for children who entered in the first quarter to exit care, and 21.7 months for children who entered in the first half (i.e., the median) to exit care. Median duration in care increased in the year prior to the implementation of the Kent Model (FY 2017) and continued to increase slightly in the first 2 years of WMPC implementation compared to the historic baseline, from 18.6 months for children entering care in FY 2017 to 20.3 months in FY 2018 and 21 months in FY 2019 (see Figure 3-12). Median duration in care declined in FY 2020 to 17 months, but increased to 21.7 months for children entering care in FY 2021. Too many children were still in care at the end of FY 2022 to observe median duration for the most recent full year of WMPC implementation (FY 2022).

Table 3-5. Quartile duration in months by state Fiscal Year of child entry in Kent County

	Pre-implementation			Post-implementation				
	2015	2016	2017	2018	2019	2020	2021	2022
25th Percentile	6.7	7.6	8.8	11.8	10.2	8.6	10	7
50th Percentile (Median)	14.5	18.2	18.6	20.3	21.0	17.0	21.7	--
75th Percentile	25.9	27.0	28.4	31.0	32	28	--	--

Figure 3-12 compares median duration in Kent County to the rest of the state. Median duration was somewhat higher than the rest of the state in the 2 years leading up to the pilot (FYs 2016-2017) and remained higher for the first 2 years of the pilot (FYs 2018-2019). For children entering care in FY 2018 and FY 2019, it took about 3 months longer for the first half of the cohort to exit care in Kent County than the rest of the state. Kent County's median duration dropped to 17 months for child entering care in FY 2020, nearly 4 months shorter than the rest of the state. This drop in duration corresponds to a statewide Rapid Permanency initiative implemented in April 2020.[33] For the FY 2021 entry cohort, median duration in Kent County increased to 21.7 months, which is slightly higher than the rest of the state (20.4 months).

Figure 3-12. Median duration in months by state Fiscal Year of child entry in Kent County and the rest of the state

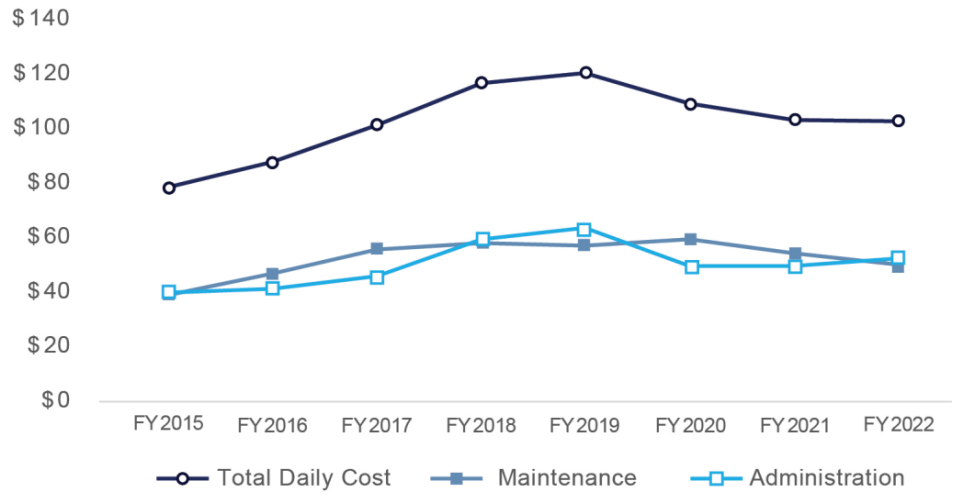


[33] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

3.1.1.4 Average Daily Unit Costs

Figure 3-13 displays the trend in the overall average daily unit cost of care across time along with the unit cost of the two major components of placement expenditures—average maintenance and administration daily costs.[34,35] "Average unit costs" are calculated by dividing the total annual placement expenditures by total placement days for each Fiscal Year. In Kent County, for out-of-home placements (excluding URM, YAVFC, JJ, and OTI), the overall average daily cost per care day increased each observable year from FY 2015 through FY 2019. The largest increase in average daily unit cost occurred during the baseline period (FYs 2015-2017), when the average daily unit cost increased by 29 percent. The average daily unit cost rose during the first 2 years of implementation (FYs 2018-2019) and decreased between FY 2020 and FY 2022. From the 2019 high, the average daily unit cost decreased by 17 percent by FY 2022, returning to pre-pilot levels. As shown previously (Table 3-4), CCI and emergency shelter days increased during the baseline period (FYs 2015-2017) while foster care days decreased. Thus, the observed increase in average daily maintenance cost during the baseline period most likely stems from a shift to more expensive care types (i.e., CCI care) and away from less costly ones (foster care). The average daily maintenance cost of placements during the pilot was steady between FY 2018 and FY 2019 before increasing in FY 2020 and then declining between FY 2020 and FY 2022. These decreases during the latter years coincided with a period when the total care days used by each placement type declined, but the placement mix shifted. The proportion of days spent in more expensive CCI, EFC, and IL placements increased in FY 2020 as the proportion of days spent in less expensive care settings, foster care and kinship care, declined (see Figure 3-8). In FY 2021 and FY 2022, congregate care use shifted to relatively less costly EFC (see Figure 3-8). Additionally, the state increased placement maintenance per diem rates for congregate care in April 2021, contributing to increased CCI daily unit costs.

Figure 3-13. WMPC-related average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation



[34] Based on information provided by MDHHS, family foster care per diem rates are $17.24 for children aged 0-12 and $20.59 for children aged 13-18. There is also a difficulty of care supplement ranging from $5-$18 a day depending on the child's age and whether or not they are medically fragile.

MDHHS FOM 905-3. Foster Care Rates: Foster Family Care and Independent Living – Effective 10/1/2012. https://dhhs.michigan.gov/OLMWEB/EX/FO/Public/FOM/905-3.pdf#pagemode=bookmarks.

[35] CCI per diem rates range from $254-$689 depending on rate type.

The average daily administrative cost increased by 15 percent during the baseline period (FYs 2015-2017) and continued to rise during the first 2 years of the pilot. By FY 2019, the average daily administrative cost of a placement increased by 40 percent above FY 2017 levels. This increase was fueled by increases in the administrative daily rate paid to providers at both the state- and WMPC-levels. FY 2020 saw a decrease in the average daily administrative rate as WMPC adjusted the daily rate being paid to providers from $48 to $46.20, leading to a small reduction of the average daily (administrative) unit cost (1%) between FY 2020 and FY 2021. Administrative daily unit costs started to increase again in FY 2022 when the PAFC admin rate was raised to $55.20 across the state.

Average daily maintenance costs fluctuated during the pilot. The average daily maintenance cost of foster care stayed fairly stable from the pre-implementation period to the pilot period. However, the average daily maintenance cost of CCI placements increased substantially in the last 2 years and has grown by 44 percent since the beginning of the pilot. The average daily maintenance cost of CCI placements was approximately $350 during the pre-implementation period and up to FY 2020; it then increased to over $430 per day in FY 2021 and $489 per day in FY 2022. The increased cost is a combination of higher level CCI placements (e.g., mental and behavioral health stabilization with lower staffing ratios) and a statewide policy that increased per diem rates for qualified residential treatment programs (QRTP) by 7 to 22 percent (depending on level of care) in April 2021 (see Figure 3-8).

The shift to more expensive CCI facilities could be due to an increased acuity in cases, or an indirect result of a policy shift that changed the approval process for residential care placements, or both. Although WMPC uses contractual, state CCI rates, the process for determining the appropriate provider for a CCI placement has changed. Prior to the pilot, a placement acceptance request needed to be submitted and then receive MDHHS leadership approval, but currently, WMPC has authority to determine the appropriate provider. As a result, while WMPC decreased utilization of congregate care while increasing days spent in less costly EFC, the increased cost per day for CCI placements counteracts some of the savings reflected in the average daily unit cost of care.

Figure 3-14 shows the average daily unit costs for maintenance and administration in the rest of the state. Average daily unit rates in the rest of the state have been consistently lower than Kent County both before and during the pilot. This is partially explained by the fact that Kent County is more privatized than the rest of the state, and agencies receive a placing agency administrative rate. Additionally, administration costs in the rest of the state did not climb as much in FY 2018 when WMPC increased the administrative per diem over state-level placing agency rates. Maintenance rates have also increased more in Kent County than the rest of the state. While Kent County maintenance rates have increased between FY 2015 and FY 2020, rates in the rest of the state stayed steady during that period; rates in both places decreased during FY 2021 and FY 2022, but decreased slightly more across the rest of the state. This is, in part, explained by Kent's utilization of more costly care types, including somewhat higher use of congregate care settings both before and after the pilot, and increasing utilization of enhanced foster care during the pilot (see Figures 3-8 and 3-9). Administration unit costs for the rest of the state increased in FY 2022, which can be connected to a statewide increase in the PAFC admin rate to $55.20.

Figure 3-14. Rest of the state average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation

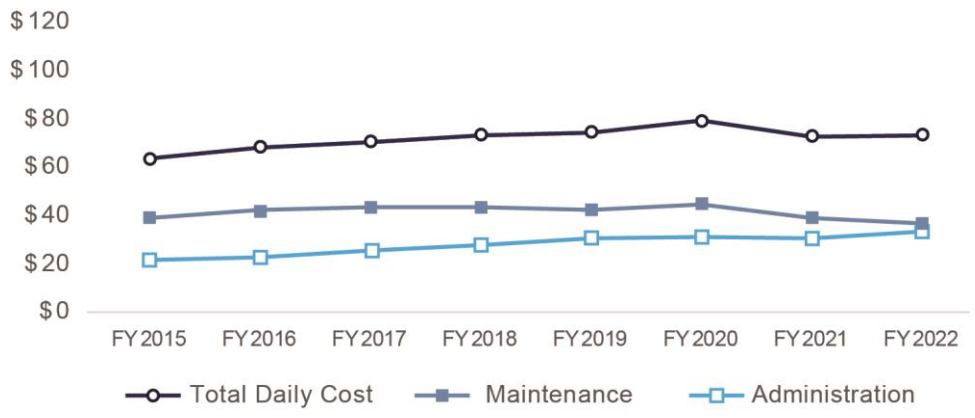
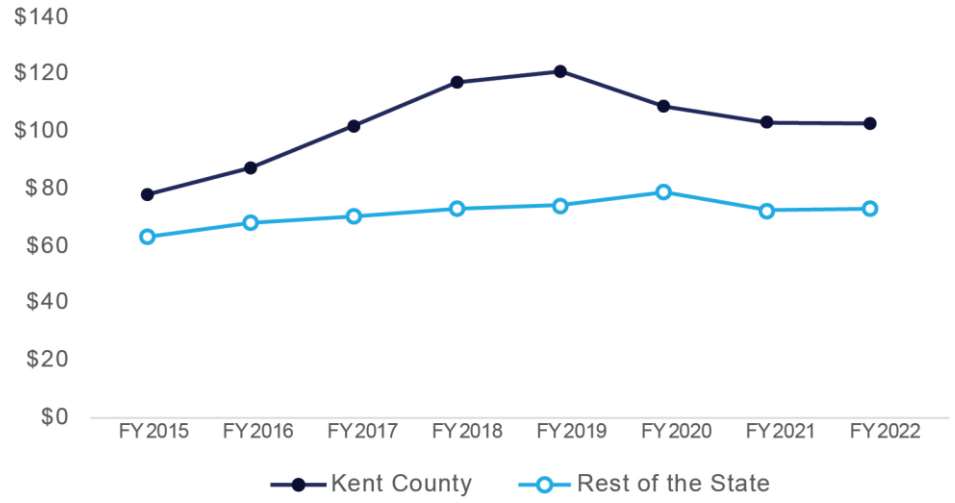


Figure 3-15 compares the total average daily unit cost of care in Kent County to the rest of the state. In FY 2015, Kent County's average daily unit cost was 23 percent higher than the rest of the state. This difference grew to 43 percent higher in FY 2017. The average daily unit cost in care grew slowly and steadily in the rest of the state until dipping in FY 2021 and remaining steady in FY 2022, while Kent County saw greater variability. In FY 2022, the average daily unit cost in Kent County was 40 percent higher than the rest of the state. Average daily unit costs fluctuated more in Kent County than in the rest of the state, but ended closer to pre-pilot levels—compared to FY 2017 levels (the last pre-pilot year), average daily unit costs in Kent County were 1 percent higher by FY 2022, and in the rest of the state, they were 4 percent higher. As discussed previously, Kent's overall higher daily unit costs are related to placement agency administrative costs and utilization of more costly care types (see Figures 3-8 and 3-9). For example, the average daily maintenance cost of congregate care increased 44 percent in Kent County during the pilot compared to only 3 percent in the rest of the state. While Kent County and the rest of the state use the same per diem rates, Kent County has increasingly placed children in higher levels of congregate care (e.g., lower staffing ratios) with higher rates.

Figure 3-15. WMPC-related and the rest of the state – Average daily unit cost for out-of-home placements by Fiscal Year, adjusted for inflation



3.1.1.5 Adequacy of the New Case Rate (Now Capitated Allocation) to Cover the Cost of Services

Research Question: To what extent does the WMPC case rate (and subsequent capitated rate) fully cover the cost of services required under the contract?

For the first 3 years of the pilot (FYs 2018-2020), WMPC was paid for services via a semi-annual case rate payment. However, at the end of FY 2019, case rate revenue was found to be $5.5 million short of covering expenditures. The cost study team conducted a review of the factors contributing to this shortfall and submitted a detailed memo to MDHHS in September 2020. A summary of those findings is included below.

Demand and price are the two primary fiscal drivers that impact child welfare expenditures. Because the cost study team found no evidence of demand being an issue in this case, for this analysis they focused on the price of care by looking at the administrative and maintenance reimbursement rates paid per day in care. Many changes were made to maintenance and administrative daily rates, both at the state and WMPC levels, during the pilot. Due to various state-initiated rate increases, the average rate per day in care was 8 percent higher in FY 2018 and FY 2019 when compared to FY 2016 levels. On top of that, additional rate increases and adjustments to rate payment structures WMPC implemented increased the average cost per day by an additional 11 percent, or $10 per day (see Table 3-6). WMPC fiscal policy changes with the largest impacts were:

1. Paying maintenance rates for kinship placements – This additional payment increased the average cost per day by 34 percent. However, it is important to note that beginning in April 2019, the state began requiring payments to kin providers as well, so this discrepancy from state rate levels does not apply to kinship placements after April 2019.

2. Increasing the PAFC administrative (i.e., staffing) rate – Increasing the administrative rate 8 percent above state levels beginning in FY 2018 accounted for 28 percent of the price increase for days in care. In FY 2020, WMPC lowered the administrative rate to state levels.

3. Increasing CCI maintenance costs – During the Kent Model, the average daily maintenance rate for a day in a CCI facility rose by 8 percent. This change attributed 20 percent to the overall price increase during the pilot and could be due to an increased acuity in cases, and/or, be an indirect result of a policy shift that changed the approval process for residential care placements.

4. Shifting the administrative payment structure – Shifting the payment of administrative rates from a utilization to a capacity structure for shelter beds increased the average rate per day by 14 percent. The Kids First shelter closed in FY 2021, leading to an elimination of these costs.

Table 3-6. WMPC fiscal policies and the total estimated fiscal change attributable to each in FY 2018 and FY 2019

WMPC Fiscal Policy[36]	Total $ change attributable to policy	% of total increase	Average daily rate change
Paying maintenance rates for kinship placements	$2,446,668	34%	$3.99
Increasing the administrative (i.e., staffing) rate	$2,011,942	28%	$3.28
Increasing CCI maintenance rates	$1,421,497	20%	$2.32
Shifting the administrative payment structure	$1,005,196	14%	$1.64
Shifting the maintenance payment structure for shelter	$223,379	3%	$0.36
Changing rates and process for DOC payments	$153,474	2%	$0.25
Total increase	**$7,262,155**	**100%**	**$11.85**
Providing EFC	($1,188,128)	-16%	($1.94)
Total change	**$6,074,027**		**$9.91**

Before considering EFC savings, these fiscal policies accounted for an estimated increase of $7.26 million over business as usual in the first 2 years of the pilot. Partially balancing these increases in costs was the implementation of EFC. If we assume that all EFC during the Kent Model would have been paid at CCI rate levels, the provision of EFC would have offset about 16 percent of the other cost increases, bringing the total increase to an estimated $6.07 million in the first 2 years of the pilot. Additionally, although WMPC saw a move to less restrictive placement settings (more kinship and less CCI and shelter) in FY 2019, a shift within CCI placements toward facilities with higher reimbursement rates cancelled out the majority of those savings.

When looking at case rate revenue on a per diem basis, WMPC received approximately $95 per day in FY 2018 and FY 2019. This level of revenue would have covered the state rates inherent in the price of care but did not cover the rate adjustments WMPC made. The average daily reimbursement rate under WMPC in FY 2019 was about $104, and 9 percent higher than the daily revenue received. Extrapolated out, given the total care days experienced in the first 2 years of the pilot, this difference between revenue and expenses amounts to an approximately $5.5 million gap between expenditures and revenue. Put another way, the case rate revenue proved sufficient to cover all state-mandated rate adjustments, but left no room to cover any additional expenses tied to the WMPC fiscal policy changes.

[36] One major fiscal change excluded from this analysis is the administrative cost of the WMPC itself (i.e., the consortium cost). Since this is not a direct placement expense and is accounted for by a separate portion of the case rate payment, we have excluded it from the analysis included in this memo.

Beginning in FY 2021, the pilot shifted to a capitated allocation model. The allocation amount was developed by Public Consulting Group (PCG) based on historic spending and the average number of children served in Kent County—$36,975,656 for FY 2021, which was lowered to $34,467,356 for FY 2022, and remained at that amount in FY 2023. The WMPC administration rate increased in FY 2023 from $2,000,000 to $2,194,000 to include the raised Detroit Consumer Price Index. The cost study team has monitored spending under the capped allocation on a quarterly basis, using care day projections to estimate spending against the capped allocation before the end of the year. Each cost monitoring memo between FY 2021 and FY 2022 has shown that WMPC is spending substantially less than the capped allocation. Based on the $23.6 million for FY 2021 and $19.5 million for FY 2022 in private agency expenditures (excludes WMPC administration) shown in Table 3-1, WMPC spent approximately 60 percent of the capped allocation over the past 2 years, leaving a surplus of more than $28 million for FYs 2021 and 2022 combined. While some surplus is desirable under a prospective payment model to account for risk and allow for investments in improving the process and quality of care, this amount is larger than expected.

As discussed earlier, the large surplus is driven by reduced care day utilization in FYs 2020 through 2022 compared to the earlier years in which the capped allocation amount was based. A combination of much lower child admissions to care and decreased duration in care for the FY 2020 entry cohort contributed to declining care day utilization, resulting in lower expenditures than the capped allocation could have supported. Approximately half as many children entered care in FY 2020 compared to FY 2019, and entries continued to decline in FY 2021 and FY 2022. Although some of the change in admissions might be attributable to the pandemic, the admission decline was already underway in the 6 months ahead of the pandemic. Additionally, while length of stay was on the rise for children entering care between FYs 2017 and 2019, duration for children entering care in FY 2020 dropped slightly, contributing to lower care day utilization in FY 2021 and FY 2022.

In addition, several of the WMPC policies that contributed to higher costs than the case rate could support were discontinued. WMPC adjusted the administrative rate to state levels, the rest of the state implemented paid kinship care, and the emergency shelter that was funded based on capacity was closed. These changes contributed to a lower average daily unit cost of care in FYs 2020-2022 compared to the first 2 years of the pilot. As a result, WMPC spent less on these policies in FYs 2021-2022 when the capped allocation was based on spending levels that could support these policies.

3.1.1.6 Cost Effectiveness Analyses

Research Question: What are the cost implications of the outcomes observed under the transition to the Kent Model?

The cost study team uses fiscal data linked to child out-of-home placement spells to assess the relative cost of achieving different outcomes. The cost per spell is the total of administrative and maintenance expenditures incurred while the child was placed out-of-home. Child-level costs for a placement spell were calculated for children in care in Kent County and for the comparison group identified by University of Michigan through PSM for use in the outcome study. The groups that are compared also mirror the outcome study—children who were in care when the pilot started on 10/01/2017, and those who entered care during the pilot (FYs 2018-2022). If the matched children were missing fiscal records, they were not included in the analysis.

The child-level costs by the two most common discharge reasons (adoption and reunification, see Table 3-14 in the outcome section) are summarized in Table 3-7 and Figure 3-16. Other discharge reasons (e.g., guardianship) had too few exits to calculate descriptive statistics. For children

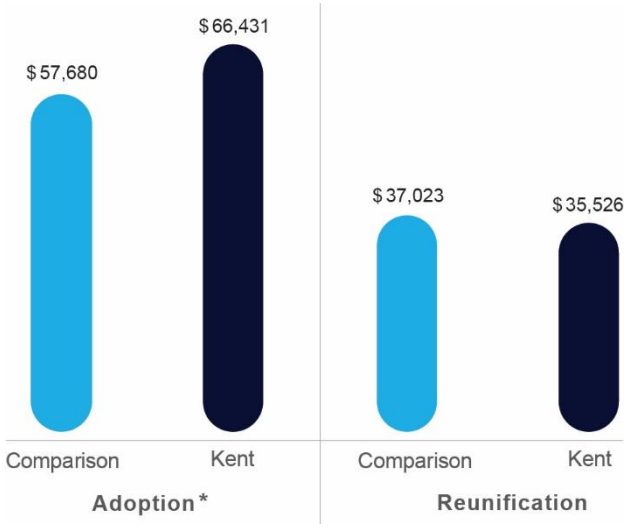
entering care after the pilot began, the average cost of achieving reunification was 4 percent lower in Kent County ($35,526) than in the comparison group ($37,023), which may correspond with a shorter time to reunification observed by the outcome study (see Table 3-15). However, this difference was not statistically significant in terms of costs.

Table 3-7. Cost per discharged child, out-of-home placement spell by discharge reason

	Exit type	Child count	Mean	SD	25th percentile	Median	75th percentile
Comparison, entered care after 10/01/2017	Adoption	203	$57,680	$26,813	$40,863	$55,487	$69,627
	Reunification	312	$37,023	$41,992	$14,227	$28,578	$46,444
Comparison, in care prior to 10/01/2017	Adoption	251	$65,836	$43,970	$43,781	$56,339	$74,361
	Reunification	365	$48,351	$54,614	$20,351	$35,499	$58,004
Kent, entered care after 10/01/2017	Adoption	298	$66,431	$30,938	$44,235	$61,465	$79,927
	Reunification	483	$35,526	$36,178	$9,787	$28,390	$48,153
Kent, in care prior to 10/01/2017	Adoption	218	$72,566	$38,722	$53,394	$64,957	$80,351
	Reunification	227	$62,165	$52,111	$26,222	$50,236	$78,800

The average cost of completing an adoption for children who entered care after the pilot began was significantly higher in Kent County than in the comparison group—$66,431 compared to $57,680 (p=0.003). The outcome study did not find a significant difference in the time to adoption, but Kent County tends to have a higher average daily cost of care, which could explain why adoptions cost slightly more. This is especially true for children who were in care during the first 2 years of the pilot, when Kent County implemented policies that increased the average daily unit cost of care compared to the rest of the state (e.g., a higher PAFC administration rate and paid kinship care).

Figure 3-16. Average cost per out-of-home placement spell for children entering care after 10/01/2017 and discharged from care as of 10/01/2022



* Indicates p<0.05

The costs per spell tend to be higher for children who were already in care when the pilot began. This is not surprising considering that the children entering care prior to FY 2018 have had longer to exit, and these amounts include children who spent more days in care accumulating higher costs. The sample of children who entered care after the pilot began in FY 2018 is more censored, meaning that children with longer—and thus more costly—placement spells were still in care at the end of FY 2022, and we cannot yet observe their final outcomes.

3.1.2 Summary of Cost Study

Fiscal trends during the baseline period—3 years prior to implementation of the Kent Model—were characterized by rising costs. After adjusting for inflation, overall child welfare expenditures rose by 12 percent from FY 2015 to FY 2017, with much of that increase driven by a rise in maintenance costs (which increased by 29 percent during the baseline period) and CCI maintenance costs, in particular (which increased by 54 percent during the same period). This rising cost trajectory continued into the first year of the Kent Model. In FY 2018, overall child welfare expenditures, maintenance expenditures, and CCI maintenance costs continued to rise, by 20 percent, 7 percent, and 8 percent, respectively. In addition, placement administrative expenditures spiked in FY 2018, rising by an annual change of 33 percent. The average daily unit cost of care also increased simultaneously.

However, the fiscal picture in FY 2019 demonstrated some significant changes. Overall child welfare expenditures continued to rise, but by a smaller annual percentage (5%), and maintenance costs plateaued—only rising by less than 1 percent. Placement administrative costs rose, however, at a slower rate (10%) than the year before. Following the same trend, the average daily unit cost of care increased again in FY 2019, but at a slower rate of growth than the previous year. The slowing in placement maintenance costs is notable and coincides with a shift in care-day utilization beginning in FY 2020. Through a reduction in total CCI care days utilized (i.e., a shift in placement mix to less restrictive and less expensive settings) and WMPC's policy decision to lower the PAFC administration rate to state levels, the average daily unit cost per care day decreased in FY 2020 through FY 2022.

Impacted by significant dips in total care day utilization, Kent County child welfare expenditures experienced a large decline, beginning in FY 2020, and continued to drop in FYs 2021 and 2022. Simultaneously, the average daily unit cost of care decreased in FY 2021 and again in FY 2022, while the rest of the state maintained relatively consistent daily unit costs. Kent County increased utilization of kinship care and enhanced foster care during the pilot, while decreasing the portion of days spent in congregate care. Yet the care days spent in congregate settings were more costly, driven by utilization of residential programs with higher per diem rates (e.g., mental health and behavior stabilization). As a result, some of the potential savings from expanded utilization of EFC were offset by more costly congregate care placements.

Child placement and duration trends underlying the fiscal data help explain the slight increase in care day utilization for FYs 2018 and 2019, compared to the baseline period, and decrease in FYs 2020 through 2022. The number of children entering care remained fairly stable during the baseline period and into FY 2018 but declined slightly in FY 2019. At the same time, the median duration in care increased in FYs 2016 and 2017 leading up to WMPC implementation (in 2017) and continued to rise for children entering care in FYs 2018 and 2019. Accordingly, the slight upturn in care day utilization in FYs 2018 and 2019 was driven mainly by children spending more time in care, not by increased child entries. Child entries declined dramatically in FY 2020 and continued to decline in FYs 2021 and 2022, driving a reduction in care day utilization. At the same

time, median duration for children entering care in FY 2020 declined compared to FYs 2018 and 2019, contributing to lower caseload counts and reduced care day utilization.

The cost study team also assessed the costs per outcome using the comparison groups the outcome study team identified. For children entering care after the pilot began, there was not a significant difference in the cost of achieving reunification, but adoptions in Kent County cost slightly more. The higher cost of exiting to adoption is linked to longer durations for children entering care in FYs 2018-2019 and Kent County's higher average daily unit costs of care. Children who spend more time in care accumulate more daily costs during their out-of-home placement spell, and adoption typically takes longer than reunification. While the difference was not statistically significant, achieving reunification descriptively costs slightly less in Kent County, which can be explained in part by reduced durations in care for children entering care in FY 2020. However, median duration increased again for the FY 2021 entry cohort and these savings may be lost for children exiting care to reunification in the coming years.

A review of the case rate model used for the first 3 years of the pilot found that fiscal policy decisions made by WMPC contributed to the shortfall between case rate revenue and actual expenditures. WMPC switched from a case rate to a capitated allocation funding model based on historic spending levels in FY 2021. However, the recent trends discussed above (i.e., declining child admissions and care day utilization) have led to lower spending in FY 2021 and 2022. As a result, WMPC currently has a substantial surplus relative to what the allocation would cover. This large surplus gives WMPC the opportunity to make strategic investments to improve services, which could include expanding EFC to reduce high-cost CCI placements.

Moving forward, the cost study team recommends changing to a prospective payment structure that provides WMPC with revenue closer to actual child serving needs, and incentivizes providers to improve outcomes (see Appendix E). This would involve establishing baseline outcomes and projecting spending using trends in care day utilization, admissions, and length of stay. Private agencies would then be rewarded based on quality/process of care improvements and the outcomes they achieve.

3.2 Outcome Study: Safety, Permanency, and Stability

This section of the report covers safety and permanency outcomes for children who entered care in Kent County after 10/1/2017 until 9/30/2022, and includes their outcome results through 10/14/2022. The following analyses focus on whether children served by WMPC achieved significantly better outcomes than children served by private agencies in other counties. Table 3-8 presents demographics of children in care and indicates that the PSM method for creating the comparison group resulted in equivalent groups (e.g., no statistically significant differences across race, ethnicity, gender, and age). Unless otherwise specified, comparisons are made between (1) total populations in Kent County and the comparison group, and (2) children in care after 10/1/2017 in Kent County and the comparison group.

Table 3-8. Demographics of children in care		
	Kent	**Comparison**
Total (N)	**2,077**	**2,062**
In care prior to 10/1/2017 (legacy)	763	770
In care after 10/1/2017	1,314	1,292
Age (at removal date) mean and standard deviation	M = 6.5 sd = 5.6	M = 6.5 sd = 5.6
Male	51.6%	51.1%
Hispanic	16.5%	15.8%
Black	31.8%	32.2%
White	49.4%	49.3%

3.2.1 Safety

Research Question: Does the Kent Model improve the safety of children?

3.2.1.1 Maltreatment Recurrence

What percentage of children experience maltreatment recurrence? To answer this question, we isolate the most recent Child Protective Services (CPS) report (Categories I, II, or III[37]) *prior* to removal, and the most recent CPS report (Categories I, II, or III) *after* removal. Table 3-9 displays the proportion of children who experienced their second substantiated report within 365 days. Chi-square tests indicate that there are no statistically significant differences between children served through the Kent Model and the comparison group. It is important to note that the risk of recurrence may appear low (relative to the Child and Family Services Review [CFSR] statewide average[38]), but that is because all of these children were in care for at least some (if not all) of the period under observation (365 days). In contrast, the state rates of recurrence are calculated on any child with two substantiated allegations within 365 days[39] (and the vast majority of those children are not removed from the parental home). No differences were observed between children in Kent County and the comparison group, either as a whole or when the post-program implementation groups (children in Kent County who entered care after 10/1/2017, and children in the comparison group who entered care after 10/1/2017) were examined by fiscal entry year.

[37] Category III dispositions apply to cases in which the county DHHS agency determines that there is a preponderance of evidence of child abuse or neglect, and the risk assessment indicates a low or moderate risk. A referral to community-based services must be made by CPS. Category II dispositions apply to cases in which DHHS determines that there is a preponderance of evidence of child abuse or neglect, and the risk assessment indicates a high or intensive risk. Services must be provided by CPS, in conjunction with community-based services. Category I dispositions apply to cases in which DHHS determines that there is a preponderance of evidence of child abuse or neglect, and a court petition is needed and/or required. As with Category II dispositions, services (or foster care) must be provided by CPS, in conjunction with community-based services.

[38] Children's Bureau: An office of the administration for children & families. "Outcomes 1 and 2: Safety." Gov. Child Welfare Outcomes Report Data. Accessed February 16, 2023. https://cwoutcomes.acf.hhs.gov/cwodatasite/recurrence/index.

[39] Child Welfare Capacity Building Collaborative. "CFSR R4 SWDI Recurrence of Maltreatment." Accessed February 16, 2023. https://capacity.childwelfare.gov/states/resources/cfsr-r4-swdi-recurrence-of-maltreatment.

Table 3-9. Second substantiation within 1 year			
Group	No recurrence	Experienced recurrence	Total
Comparison, entered care after 10/1/2017	95.0% (1,228)	5.0% (64)	2,062
Comparison, in care prior to 10/1/2017 (legacy)	93.8% (722)	6.2% (48)	770
Kent, entered care after 10/1/2017	93.3% (1,226)	6.7% (88)	2,077
Kent, in care prior to 10/1/2017 (legacy)	93.4% (713)	6.6% (50)	763
Total	94.0% (3,889)	6.0% (250)	5,672

3.2.1.2 Maltreatment in Care

What percentage of children experience maltreatment while in foster care? Table 3-9 displays the risk of maltreatment in care (MIC) at any point in the child's foster care episode. Specifically, we assessed the percentage of children in each group who experienced a Category I-III disposition while they were in an out-of-home placement setting or still under the legal guardianship/ supervision of the state. This measure is similar to the Child and Family Service Reviews (CFSR) round three approach to MIC, although we display the estimates in percentages rather than as a rate per 100,000 days of care. Overall, 8.8 percent of children experienced MIC or a Category I-III disposition[40] while they were in an out-of-home placement setting or still under the legal guardianship/supervision of the state (Table 3-10). There were no statistically significant differences between children served in Kent County and similar children served by private agencies outside of Kent County. The MIC survival rates for Kent and the comparison group by Fiscal Year are statistically similar.

Table 3-10. Maltreatment in care			
Group	No MIC	Experienced MIC	Total
Comparison, entered care after 10/01/2017	93.4% (1,207)	6.6% (85)	1,292
Comparison, in care prior to 10/01/2017 (legacy)	87.5% (674)	12.5% (96)	770
Kent, entered care after 10/01/2017	93.1% (1,223)	6.9% (91)	1,314
Kent, in care prior to 10/01/2017 (legacy)	88.1% (672)	11.9% (91)	763
Total	91.2% (3,776)	8.8% (363)	4,139

3.2.2 Permanency

Research Question: Does the Kent Model improve permanency for children?

3.2.2.1 Permanency Status and Length of Stay

Permanency is defined using the Federal measure that includes children who have been discharged from foster care, with the recorded reason for discharge as reunification with parents/primary caregivers, adoption, living with relatives or guardianship. Table 3-11 displays the proportion of children who exited care, the proportion of children who are still in care, and their associated length of care days (length of stay in days). We present both median and mean lengths of stay. For children who entered care after 10/1/2017, children in Kent County exited care at a higher rate than children in the comparison group (69.8% vs. 65.6%); this difference is statistically significant (*p*-value <0.001). Children in Kent County who entered care after 10/1/2017 and exited, tended to

[40] https://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_7193-159484--,00.html

stay fewer days in care, on average, than children in the comparison group (563 days vs. 643 days); this difference is also statistically significant (p-value <0.05).

Table 3-11. Exited or still in care

Group	Exit status	% (N)	Length of stay		
			Mean	Standard deviation	Median
Comparison, entered care after 10/01/2017	In care	34.4% (444)	688.6	475	548.5
	Exited	**65.6% (848)**	**642.5**	358.3	596.5
Comparison, in care prior to 10/01/2017 (legacy)	In care	4.4% (34)	2,280.3	356.1	2,157.5
	Exited	95.6% (736)	987.9	523.7	872.5
Kent, entered care after 10/01/2017	In care	30.2% (397)	623.7	447.2	533
	Exited	**69.8% (917)**$^{+}$	**563.2***	361.8	545
Kent, in care prior to 10/01/2017 (legacy)	In care	3.0% (23)	2,852.9	853.6	2,563.0
	Exited	97.0% (740)	955.7	521.4	839

* Indicates p<0.05, $^{+}$ indicates p<0.001.

Focusing more specifically on the timing associated with exits, Table 3-12 shows cumulative exits to permanency at 6, 12, and 18 months for all children who exited with each increase in time frame. A higher percentage of children in Kent County who entered care after 10/1/2017 achieved permanency within 6 months of entering care at a statistically higher rate than children in the comparison counties (15.4% vs. 8.8%, p-value <0.0001). This difference is maintained by the 12th month (28.4% vs. 23.2%, p-value <0.001) but is not observed by the 18th month.

Table 3-12. Cumulative exits to permanency

Group	Permanency within 6 months	Permanency within 12 months	Permanency within 18 months	Ever achieved permanency	Total exits (N = 3,241)
Comparison, entered care after 10/01/2017	**8.8% (75)**	**23.2% (197)**	39.9% (380)	87.85% (745)	848
Comparison, in care prior to 10/01/2017	2.2% (16)	7.5% (55)	16.6% (122)	84.38% (621)	736
Kent, entered care after 10/01/2017	**15.4% (141)**$^{++}$	**28.4% (260)**$^{+}$	41.4% (380)	87.68% (804)	917
Kent, in care prior to 10/01/2017	1.4% (10)	4.9% (36)	15.8% (117)	86.76% (642)	740

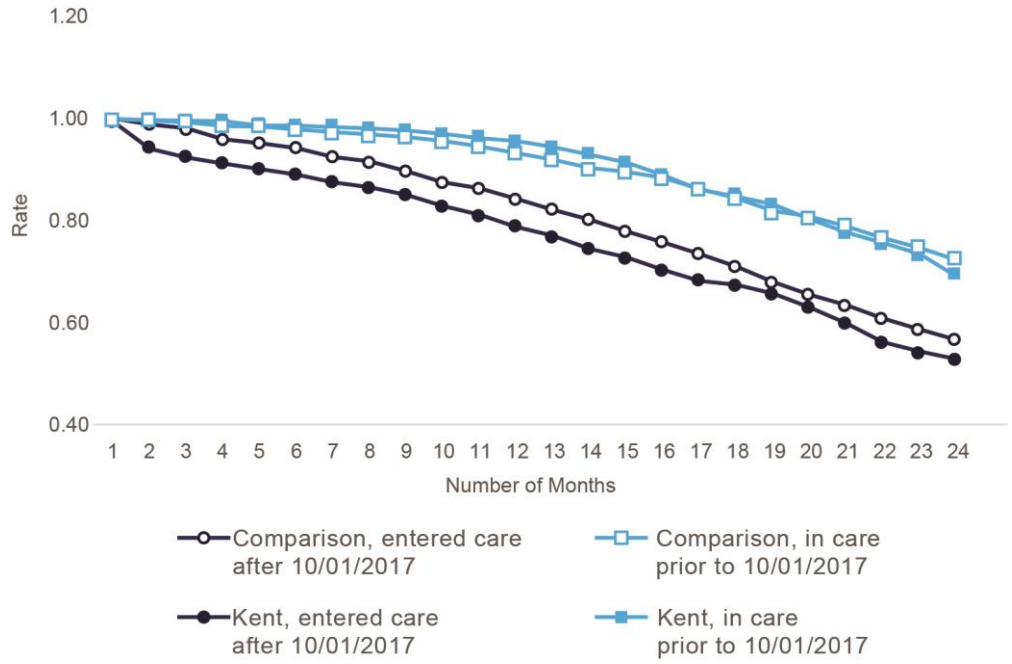
$^{+}$ Indicates p<0.001, $^{++}$ indicates p<0.0001.

Notes: The additional exit within 18 months in Kent County for children who entered care after 10/1/2017 appears to reflect a crossover case. This child's Child Welfare Continuum of Care (CWCC) enrollment date occurs after 10/1/2017, but the removal date shows the child entering care prior to the start of FY 2018. Instead of discarding this child's data from the sample, we have grouped it with data from other children who are enrolled under the CWCC program type after 10/1/2017. Also, although the groups are cumulative, the last column shows total exits and *not* total exits to permanency (i.e., "total exits" are the denominator for the column "ever achieved permanency"). Children who never achieved permanency are not included in the "ever achieved permanency" column.

Permanency Survival Rate. Figure 3-17 shows the survival rate for the first 24 months in care between the four study groups. The study team used the survival analysis method to measure the rate of exits to permanency over time and found that among children who entered care after 10/1/2017, children in Kent County exit to permanency at a significantly faster rate than children

in the comparison group (p-value <0.001). When observing the pairwise comparisons between Kent County and the comparison group by their fiscal entry year subsets, children in Kent County achieved permanency at a faster rate than children in the comparison group for children who entered during Fiscal Years 2018 (p-value <.005), 2020 (p-value <.0005), and 2022 (p-value <.05).

Figure 3-17. Permanency survival rate for study groups



Cumulative Re-Entry for Permanency Exits. For the purpose of this study, a re-entry is defined as a child's return to a substitute care setting after they have been discharged from care to a permanent placement. Children in Kent County re-enter care at a slightly lower rate at each period and overall (Table 3-13). However, this difference is not significant.

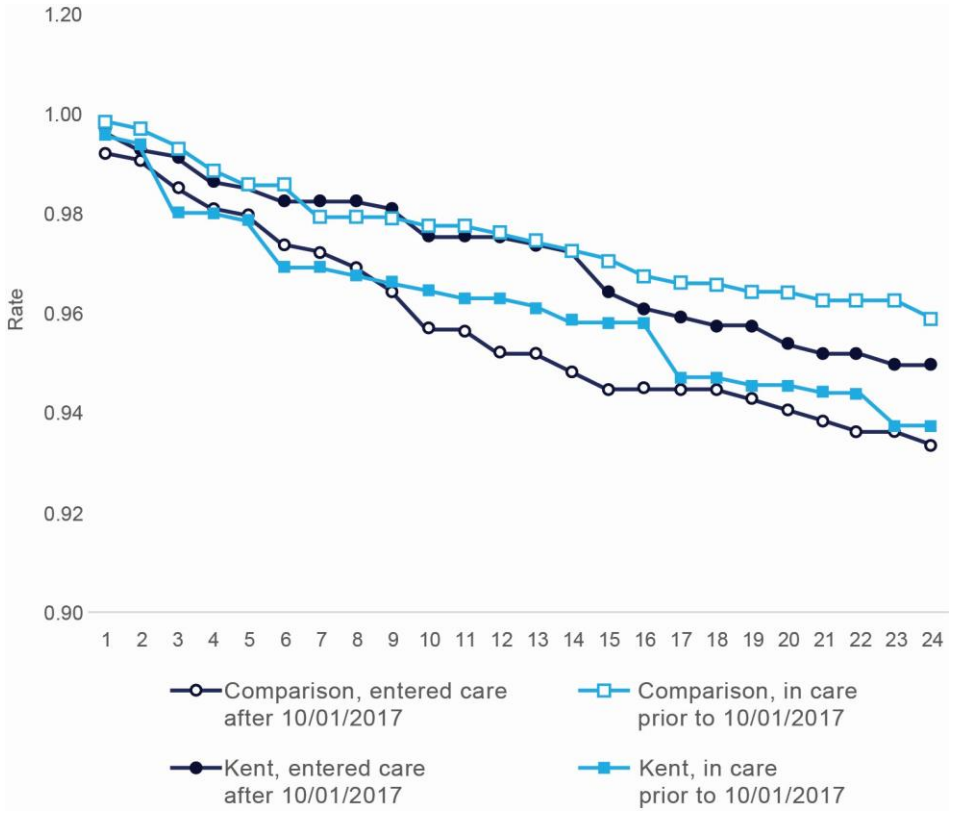
Table 3-13. Cumulative re-entries for permanency exits

Group	Returned within 6 months	Returned within 12 months	Returned within 18 months	Ever re-entered care	Total permanency exits (N = 2,812)
Comparison, entered care after 10/01/2017	2.6% (19)	4.4% (33)	5.0% (37)	7.0% (52)	745
Comparison, in care prior to 10/01/2017	1.5% (9)	2.4% (15)	3.5% (22)	5.8% (36)	621
Kent, entered care after 10/01/2017	1.7% (14)	2.5% (20)	3.7% (30)	4.7% (38)	804
Kent, in care prior to 10/01/2017	3.1% (20)	3.9% (25)	5.3% (34)	6.9% (44)	642

Re-Entry Survival Rate. Figure 3-18 shows the survival rate for re-entry within the first 24 months after children had been discharged to permanency. Using the survival analysis method to measure the rate of re-entry over time, the study team found that although children in Kent County exited to permanency at a faster rate, their re-entry rate was statistically similar to the comparison group.

When observing the pairwise comparisons between children in Kent County and the comparison group by fiscal entry year subsets, there were no statistically significant differences.

Figure 3-18. Re-entry survival rate for study groups



Permanency Categories by Study Group. Table 3-14 displays a breakdown of the different permanency categories by study group. For children who entered care after 10/1/2017, most exited to reunification. This reflects the finding that children who were in care prior to 10/1/2017 were more likely to be in care for disproportionately longer periods of time; that is, children with shorter stays had already exited the system to reunification. For children who entered care after 10/1/2017, those in Kent County exited to adoption at a *lower* rate (p-value <0.05). This helps explain the differences observed in terms of time in care since, as is shown in Table 3-15, children who exit to adoption on average are in care for longer periods of time.

Table 3-14. Permanency categories by study group				
Group	**Adoption**	**Guardianship**	**Living with other relatives**	**Reunification with parents or primary caretakers**
Comparison, entered care after 10/01/2017	**39.2% (292)**	7.7% (57)	0.8% (6)	52.3% (390)
Comparison, in care prior to 10/01/2017	62.8% (390)	6.4% (40)	0.0% (0)	30.8% (191)
Kent, entered care after 10/01/2017	**33.2% (267)***	10.2% (82)	1.1% (9)	55.5% (446)
Kent, in care prior to 10/01/2017	56.9% (365)	10.0% (64)	0.9% (6)	32.2% (207)

* Indicates $p<0.05$; bolded figures indicate the comparison yielding the significant results.

Time to Exit by Permanency Type. Reunification and adoption are the two most common types of permanency; as such, Table 3-15 focuses on the length of time between children's entry to and exit from care. The amount of time (in days) is summarized with means, medians, and standard deviations. As shown, children served through the Kent Model who entered care after 10/1/2017 exited to reunification faster than those in the comparison group (359.5 vs. 409.0 days); this difference is statistically significant (p-value <0.001).

Table 3-15. Time to exit by permanency type					
Group	**Exit type**	**N**	**Time to exit**		
			Mean	**Median**	**Standard deviation**
Comparison, entered care after 10/01/2017	Adoption	292	836.0	841.8	321.2
	Guardianship	57	716.0	718.1	358.8
	Living With Other Relatives	6	524.0	431.7	303.6
	Reunification With Parents or Primary Caretakers	390	**409.0**	503.3	374.5
Comparison, in care prior to 10/01/2017	Adoption	390	958.5	1,051.7	441.1
	Guardianship	40	908.5	1,041.0	707.2
	Reunification With Parents or Primary Caretakers	191	571.0	745.6	513.7
Kent, entered care after 10/01/2017	Adoption	267	834.0	852.1	263.0
	Guardianship	82	734.5	688.2	328.5
	Living With Other Relatives	9	13.0	54.6	58.7
	Reunification With Parents or Primary Caretakers	446	**359.5+**	416.6	333.7
Kent, in care prior to 10/01/2017	Adoption	365	959.0	1,027.6	420.7
	Guardianship	64	799.0	824.2	314.7
	Living With Other Relatives	6	1,265.0	1,457.2	673.9
	Reunification With Parents or Primary Caretakers	207	599.0	759.7	512.0

+ Indicates p<0.001; bolded figures indicate the comparison yielding significant results.

Table 3-16 displays cumulative exits to permanency for older youth at 6, 12, and 18 months from their removal date. Older youth (defined here as youth ages 16-18) typically face challenges that are different from others in foster care with respect to reaching permanency, such as rarely exiting to adoption, which is typically more achievable for younger children. As such, one has to consider whether these youth would be best served under the Kent Model. Unfortunately, the overall number of children in this age range across the study groups is quite small (the total is approximately 5% of the entire sample). While this does not preclude their importance, it poses difficulties (for reasons of statistical power) to evaluating and detecting differences between the youth served through the Kent Model and youth in the comparison group. In previous iterations of this evaluation report, there were differences between youth in Kent County and the comparison group, but they did not reach statistical significance (again, related to low statistical power). In this final report, there is enough power, and the differences reach statistical significance. For older youth exiting care, those associated with the Kent Model are significantly *more likely* to achieve permanency than older youth in the comparison group within 12 months (p-value <0.05), but significance is not reached for the difference between the permanency within 18 months nor the ever-achieved permanency measures (Table 3-16). When comparing children in Kent County and the comparison group by Fiscal Year subgroups, there were no notable differences found.

Table 3-16. Cumulative exits to permanency for older youth

Group	Permanency within 6 months	Permanency within 12 months	Permanency within 18 months	Ever-achieved permanency	Total exits (N = 257)
Comparison, entered care after 10/01/2017	8.0% (6)	**13.3% (10)**	24.0% (18)	34.7% (26)	75
Comparison, in care prior to 10/01/2017	3.2% (2)	4.8% (3)	7.9% (5)	12.7% (8)	63
Kent, entered care after 10/01/2017	18.3% (13)	**31.0% (22)***	35.2% (25)	43.7% (31)	71
Kent, in care prior to 10/01/2017	0% (0)	4.2% (2)	12.5% (6)	35.4% (17)	48

* Indicates p<0.05

3.2.3 Placement Stability

Placement stability is important to children's safety, well-being, and permanency; placement permanency is delayed when a child experiences multiple placements and well-being is affected in multiple ways, including poorer educational outcomes as a result of changing schools, and increased behavioral and mental health issues (Center for Advanced Studies in Child Welfare, 2010). Thus, it is important to minimize the number of placement changes a child experiences while in foster care. Table 3-17 shows the number and percentage of children in each group who have experienced fewer than two placement changes (beyond their initial setting when entering care) versus those who have experienced two or more placement changes. No significant difference in experience of placement changes was found between children in Kent County and the comparison group. There were also no notable differences between groups when observed by Fiscal Year.

Table 3-17. Placement stability			
Group	2+ changes	<2 changes	Total
Comparison, entered care after 10/01/2017	43.6% (325)	56.4% (420)	1,292
Comparison, in care prior to 10/01/2017	52.5% (326)	47.5% (295)	770
Kent, entered care after 10/01/2017	38.4% (309)	61.6% (495)	1,314
Kent, in care prior to 10/01/2017	51.7% (332)	48.3% (310)	763
Total	45.9% (1292)	54.1% (1520)	4,139

3.2.4 Summary of Outcome Study

The outcome study focuses on safety, permanency, and placement stability, common outcomes in child welfare evaluation studies. The outcomes were estimated and displayed across four unique groups of children. These groups include: (1) children in care in Kent County prior to 10/1/2017; (2) a matched group of children associated with counties other than Kent County prior to 10/1/2017; (3) children in care in Kent County after 10/1/2017; and (4) a matched group of children associated with counties other than Kent County after 10/1/2017. Propensity score procedures were used to create the matched groups. Children in the matched comparison group spent at least 80 percent of their time served by a private agency outside Kent County.

- **Safety.** No significant differences emerged between children in Kent County and children in the matched comparison group with regard to safety. For the purposes of the current evaluation, safety is defined as maltreatment in care or recurrence of maltreatment.

- **Permanency.** Among children who entered care after 10/1/2017, children in Kent County achieved permanency by 6 and 12 months at a higher rate than children in the comparison group. This difference disappears by the 18th month. Children in Kent County who entered care after 10/1/2017 and exited tended to stay fewer days in care, on average, than children in the comparison group. Children in Kent County re-entered care at a statistically similar rate as children in the comparison group. Children in Kent County were less likely to exit to adoption as compared with children in the comparison group, and they exit to reunification more quickly than children in the comparison group.

- **Placement Stability.** Children in Kent County experienced two or more placement changes at a rate similar to children outside Kent County.

3.3 Process Study: Policies and Practices in Kent, Ingham, and Oakland Counties

Through the process study, the evaluation team examined if and how service provision and support is managed in Kent County, where the Kent Model is implemented, versus Ingham and Oakland counties, where the per diem model is implemented.

Kent County and the Kent Model

In Kent County, five private child placing agencies provide all child welfare foster care case management services (Michigan Department of Health and Human Services, 2019), under the oversight of WMPC. This structure is in contrast to Ingham and Oakland counties, whose structure and operations represent the standard per diem model of child welfare practice in Michigan. The following discussion of Kent County child welfare practice represents the full 6 years of the pilot evaluation, from pre-implementation of the Kent Model through the fifth year of its implementation.

3.3.1 West Michigan Partnership for Children (WMPC)

WMPC is the agency responsible for implementing the Kent Model. WMPC is the sole contractor for foster care and adoption case management in Kent County, and it subcontracts with all five of the existing private child placing agencies in Kent County to provide case management services through a collaborative consortium.

3.3.1.1 WMPC Structure and Staffing

WMPC is guided by a Board of Directors. The Board originally consisted of the heads of the five private agencies, but after the first year of implementation, WMPC recognized the need to have greater representation from community stakeholders. WMPC expanded the board to include four new members, recruited from community agencies and foster care alumni, for a total of nine board members.

Over the 6-year evaluation period, the structure of WMPC changed according to the needs of the pilot implementation. In October 2017, when implementation of the Kent Model began, WMPC staff included 14 employees; five on the leadership team, one administrative coordinator, one contracts and finance specialist, four Care Coordinators, and three performance and quality improvement (PQI) coordinators. The initial goal for the organization was to "start very lean" and assess what additional positions would be necessary over time. Since the start of implementation, WMPC has strategically added new positions to expand the capacity of the PQI, care coordination, and financial departments, and most recently, the newly created parent engagement program.

3.3.1.2 WMPC Staff Turnover and Retention

Since implementation began, WMPC has experienced turnover in nearly every staff position, including every senior leadership position, with the sole exception of the Chief Operating Officer, who moved into the role of CEO after the departure of the previous CEO at the end of 2020. Turnover in the Care Coordination team, in particular, was felt among private agency staff, who depend on Care Coordinators as their liaisons to WMPC and as a conduit for service approvals. In addition, WMPC staff in the final year of interviews noted that the turnover in WMPC leadership positions had impeded the ability of WMPC to strategize and innovate to the extent desired.

Over the years, WMPC respondents identified some of the particular challenges in recruiting and retaining qualified WMPC staff. These challenges included the high level of energy and effort required of staff in a start-up organization; the need for additional staff to support the workload; and the fact that WMPC was part of a 5-year pilot with an uncertain future. Despite these challenges, WMPC has been able to recruit qualified staff to fill vacant positions throughout the pilot.

Research Question: Do the counties adhere to the state's guiding principles in performing child welfare practice?

3.3.2 Kent Model Implementation

The Kent Model was designed based on the theory that the new funding model and oversight structure (facilitated by the WMPC) will enable foster care service providers to more fully adhere to Michigan's guiding principles for child welfare. Specifically, the flexibility in service delivery and funding, collaborative partnerships, and focus on data-driven programmatic improvement should, according to the logic of the model (Appendix C), lead to faster and more individualized services for families, better collaboration among community partners, better support to agency staff, less time in care for children (especially in residential settings), increased placement stability, and more robust data for continuous quality improvement.

3.3.2.1 Challenges and Changes to the Funding Model

Financial considerations dominated the second and third years of pilot implementation, beginning when WMPC learned that the average cost-per-case for the first year of implementation was 29 percent higher than the case rate originally projected by the analysis of 7 years of Kent County child welfare data. WMPC found itself experiencing a steadily worsening fiscal crisis and entered into discussions with MDHHS over the next 2 years about a variety of factors that might be impacting the current financial challenges, and potential solutions to these challenges. In FY 2020, WMPC and MDHHS agreed to a fundamental change to the funding model, from the original case rate model to the capitated rate funding model. Based on the capitated rate as calculated for FY 2021, MDHHS provided funding to WMPC for the establishment of a risk reserve, and WMPC submitted a budget to MDHHS that demonstrated their ability to manage costs within the capitated rate. At the time of the final year of data collection, WMPC had amassed a multi-million dollar surplus, which it planned to reinvest in the community in discussion with the private agencies and other stakeholders.

3.3.2.2 Care Coordination

A key element of the Kent Model has been the Care Coordination structure, which assigns a designated Care Coordinator to each private agency. The Care Coordinator serves as a facilitator for service approvals, a liaison with WMPC, an intermediary between private agencies and Kent County DHHS, and a source of information, assistance, and support to foster care caseworkers. Private agency staff expressed throughout the evaluation period that having a single person to go to helped them gain a consistent understanding of policies and procedures and made service referrals more efficient. However, although the model was largely considered a key factor in supporting case practice, private agency staff experiences over the years indicated that the success of care coordination depends on having the right person in the coordinator role, along with strong management of the overall program. Private agency staff described facilitating qualities of a Care Coordinator, which included responsiveness, frequent communication, proactivity in helping work more difficult cases, and a deep knowledge of the Kent County child welfare system. In the final year of data collection, respondents at each of the private agencies said that they feel supported by their current Care Coordinator.

Since early implementation, WMPC has worked to increase consistency and efficiency across the Care Coordination program by solidifying responsibilities and expectations. This included shifting some routine tasks (e.g., housing referrals, trauma assessment referrals) to the Care Coordination manager to allow the Care Coordinators more time for casework with their agencies. At the beginning of 2021, WMPC assessed the program again to identify inefficiencies and opportunities to

build further capacity. This process resulted in the creation of a new position: the Intake and Placement Coordinator. The purpose of the new position is to handle daytime child placements, as well as all residential referrals, to allow Care Coordinators to focus on supporting their assigned agency or agencies. WMPC hired the first Intake and Placement Coordinator shortly before the final year of data collection.

3.3.2.3 Enhanced Foster Care (EFC) Implementation

Since the start of implementation, EFC has been described as the most positively received component of the Kent Model. Through EFC, caregivers receive a higher foster care rate and intensive in-home services for children with higher needs; respondents universally consider EFC a substantial facilitator for transitioning or preventing children from being placed in residential care. The service provides additional support to children in foster care with behavioral and emotional needs while helping caregivers build their knowledge and skills of how to support a child with high needs. A clinical case manager and behavioral specialist also assist caregivers in supporting and guiding the youth placed with them. It also allows the flexibility to use funds creatively to support the youth. The service encourages relatives and other foster parents to care for children who might otherwise have been placed in a residential facility.

In the third year of implementation, WMPC instituted a per-agency cap on EFC cases and a process for regular case review. The cap and review process were intended to control EFC expenditures and ensure that EFC was being used as intended. In the most recent focus groups, private agency staff agreed that they were managing under the caps, especially because WMPC was able to allow some flexibility in approving a small number of additional EFC slots if the agency was at their cap. However, private agency staff also expressed the perception that, due to the COVID-19 pandemic and recent statewide reductions in the availability of residential care, they were seeing a higher proportion of children with high needs entering foster care, which increased the demand for EFC services.

Research Questions: What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services? What resources are necessary to support the successful implementation of the Kent Model?

3.3.3 Flexibility and Innovation in Case Planning

An important aspect of the Kent Model, as originally planned, was to allow private agencies greater financial flexibility to develop and implement innovative solutions to better meet the needs of children and families in the foster care system in Kent County. WMPC planned two main strategies to increase flexibility: (1) increasing the staffing rate paid to the private agencies, and (2) paying for a wider variety of innovative services through miscellaneous funding requests than would have been approved by Kent County DHHS prior to the Kent pilot. In pre-implementation, private agency staff expressed skepticism that the new model could provide this flexibility, but felt it would benefit families if it could. For its part, WMPC staff spent the first year of the pilot encouraging private agency staff to think creatively and get away from a "scarcity mindset."

3.3.3.1 Staffing Rate

Earlier in the pilot, WMPC paid private agencies a staffing rate of $48, higher than the statewide rate (set by MDHHS) of $46.20. WMPC chose to pay the staffing rate for an average number of cases served, with the intention of allowing agencies to plan without concern for short-term changes in funding based on an increase or decrease in cases. In focus groups, private agency leadership and

staff reported that private agencies used this funding for additional positions such as family finders, case aides, buffer workers (to help fill staffing gaps), and supervisors. In Year 4, WMPC lowered the rate back to the statewide rate. The lowering of the rate left some agency leaders looking for alternate funding sources to retain these positions. However, near the end of the evaluation period, state leaders announced additional 2022 Fiscal Year appropriations for MDHHS, which enabled the agency to raise the staffing rate to $55.20 statewide, a considerable increase that may allow similar flexibility to agencies across Michigan.

3.3.3.2 Innovative Services

With regard to miscellaneous funding requests through WMPC, most private agency respondents agreed that these requests allow for greater creativity in case planning, as long as the need can be justified. For example, some caseworkers described using miscellaneous funding requests to pay for counseling, specialized therapy, or other medical or behavioral health services that could not be paid for through Medicaid. Some respondents expressed that they had less flexibility or funding fluidity than they had originally envisioned at the beginning of the pilot. To find a balance between creative thinking and responsible funding, WMPC staff noted that they primarily approve funding requests that support placement stability, permanency, or reunification. At a system level, WMPC also sought to facilitate innovation by bringing the private agencies together to share innovative processes and practices with each other, which private agency respondents felt was helpful and built a stronger spirit of collaboration between the agencies. Respondents indicated that these convenings stopped happening in the later years of the pilot, likely due to the pandemic curtailing in-person meetings.

3.3.4 Interagency Collaboration

Kent County has a long history of collaboration among community partners to monitor and improve child welfare outcomes. For many years, the Kent County Family and Children's Coordinating Council, which consists of the County Administrator and representatives from Kent County DHHS, the five private agencies, the county court system, mental health and other public agencies, and multiple philanthropic foundations, has met on a quarterly basis to discuss and plan for the future direction of the Kent County child welfare system.

As the newest partner in the community, WMPC stepped up as an active participant in all areas of child welfare collaboration in early implementation. In the first few years of the pilot, respondents from public and private partner agencies expressed appreciation for WMPC's transparency, advocacy, and energy dedicated to collaboration. In particular, private agency respondents appreciated the role of WMPC in facilitating the sharing of best practices and innovations among the five private agencies, something they said rarely happened prior to the pilot. During the final year of data collection, which occurred during the COVID-19 pandemic, some private agency respondents felt that WMPC was no longer collaborating as effectively with the private agencies, nor facilitating collaboration among the private agencies.

3.3.4.1 Public-Private Agency Collaboration

Before the Kent Model, the collaborative relationship between Kent County DHHS and the five private child-serving agencies in Kent County evolved during the shift toward privatization of foster care services, and it has undergone further evolution with the advent of the WMPC and the Kent Model. This evolution has presented both facilitators and barriers. After the first year of implementation, respondents described the relationship as highly collaborative on the administrative level; however, on the line-staff level, some tension existed due to the changes in

roles and previous collaborative difficulties. In the second year of the pilot, respondents at all levels described significant improvements in the collaborative relationship between staff in Kent County DHHS and the private agencies through the efforts of DHHS and WMPC leadership to work out previous points of tension, such as the case transfer process and funding approvals.

In the final 2 years of the evaluation, respondents at Kent County DHHS, WMPC, and the private agencies described collaboration across the public/private divide as going smoothly. While staff from the public and private agencies report that they interact much less than they did before the pilot, Kent County DHHS staff still approve education mileage reimbursements and trauma assessments, as well as the initial funding stream determination for new cases. As in previous years, private agency staff may also reach out to DHHS caseworkers for questions around Medicaid, birth certificates, or other issues.

In addition to collaboration among staff in public and private child welfare agencies, another regular point of collaboration in foster care cases occurs when cases are transferred from CPS to foster care. Each private agency has a set weekly time to meet with CPS workers and supervisors about new cases. Respondents reported that these transfer meetings now occur more consistently, although WMPC and Kent County DHHS leaders are still working to improve the process. Private agency staff noted that they still have challenges obtaining copies of key CPS reports that provide important information about the family (e.g., sometimes CPS staff simply do not send the materials), and also noted that WMPC often helps them obtain missing information. Additionally, WMPC respondents reported that more collaboration with local DHHS leadership has begun occurring over the last year regarding case consultations.

3.3.4.2 Court System

For children in foster care, the Family Division of the 17th Circuit Court makes all final decisions on removals and permanency. Each judge has an individual style and priorities in their courtroom; private agency staff discussed how one judge wanted children to return home quickly, whereas another judge might wait much longer to close a case. Since the start of the pilot, WMPC leadership has met monthly with court representatives to provide updates on implementation of the Kent Model and address any emerging issues around implementation. The court as a whole has supported the Kent Model since implementation, with some judges stepping up as champions of the pilot and WMPC. Over the years, judges and court staff interviewed for the evaluation have consistently given positive feedback regarding the changes the Kent Model has brought to the child welfare system from their perspective. Court respondents described seeing faster service referrals, greater placement stability, and more use of data-driven decisionmaking.

During the COVID-19 pandemic, although the collaborative relationship with the court remained strong, judges and court staff struggled along with the rest of the system to adjust to conducting activities virtually for a time. From the foster care side, private agency staff described substantial delays in court orders and hearings due to the pandemic, which delayed adjudications, adoptions, terminations, and reunifications. As of the end of data collection, respondents reported that hearings were taking place more regularly again.

3.3.4.3 Mental Health System

Network 180 is the longstanding community mental health authority in Kent County. Like the other community partners in Kent County, Network 180 has a history of strong collaboration with the child welfare system. However, during early implementation of the Kent Model, private agency staff expressed frustration in navigating the Network 180 system to connect families with mental health

services. Kent County DHHS has a long-established Clinical Liaison position to support DHHS staff in this work; however, the Clinical Liaison was unable to also support the five private foster care agencies. In response to this need, WMPC and Network 180 created a second Clinical Liaison position, housed at WMPC, to help assess the mental health needs of children entering foster care and to consult with foster care workers on appropriate available services. By the end of evaluation data collection, most private agency staff agreed that the Clinical Liaison was helpful to their work, especially informing workers about services they might not know about, but getting services for families through Network 180 could still be a frustrating process. Specifically, Network 180 services are funded almost entirely through Medicaid, and eligibility for services is determined by the Medicaid manual. In addition, perceptions of need for certain services, or the sequence of services, may differ between private agency staff and the Clinical Liaison, leading to perceptions of gatekeeping.

3.3.4.4 Service Referrals

Prior to the launch of the Kent Model, most services for children and families were paid through Kent County DHHS contracts. Private agency workers had to submit a request to a Kent County DHHS Purchase of Service (POS) monitor for approval before they could make a referral to a service provider. Agency staff described this process as often lengthy, labor-intensive, and inconsistent, leading to substantial delays in services for families. According to respondents, the requirements for authorization and the responsiveness to the request often varied based on which monitor or supervisor was involved. Former POS monitors explained that, from their end, requirements and timeliness often varied based on changing Kent County DHHS policy or the interpretation of policy by supervisors.

Under the Kent Model, authority for approval and payment of most services rests with the WMPC, mainly through the Care Coordinator assigned to each private agency. Some services, such as determinations of care (DOC) or EFC, are authorized by either the private agency or WMPC leadership. Efficiency and consistency in processing service requests was a major pre-implementation issue for private agency staff, who have expressed increased satisfaction with the process each year since implementation began. Consistent in the final 2 years of the evaluation, private agency staff reported that service referrals now run mostly smoothly and have a reasonable turnaround time with both WMPC and Kent County DHHS. In particular, private agency staff felt that having the ability to approve DOCs in house was a significant facilitator in getting families the services they need faster from the beginning of the case.

3.3.5 Performance and Quality Improvement (PQI)

Another goal of the Kent Model pilot was the development of a continuous quality improvement (CQI) process and performance indicators that would help WMPC and the private agencies monitor and improve the quality of foster care services. WMPC sought to develop a process that added value but not additional work for caseworkers. WMPC also purchased the MindShare data analytic system with the ultimate goal of providing real-time monitoring and predictive analytics.

In early implementation, private agency leadership agreed that the WMPC PQI approach was not redundant of internal agency efforts nor of MDHHS audits, but rather addressed quality outcomes and presented performance data across the five private agencies, something that did not happen prior to the Kent Model. Many respondents were excited about the timeliness of seeing data from MindShare as well as the user-friendly presentation of it, which was contrasted with historical reports available from MiSACWIS. WMPC reviewed performance data regularly with various

stakeholders in Kent County and MDHHS, including presentations at Child Welfare Partnership Council (CWPC) meetings. Overall, WMPC intended to create a culture of shared learning, with PQI coordinators facilitating exchanges about shared successes and strategies among private agency staff and a willingness to engage in an open collaborative manner, not a competitive one.

The WMPC PQI team encountered a number of challenges throughout the evaluation period. Most significantly, the PQI division experienced frequent turnover at all levels and frequent restructuring during every year of implementation. Another challenge reported in early implementation refers to *"building the plane while you are learning to fly,"* an adage commonly found in startup efforts; that is, the need to create the CQI processes while also building the infrastructure can be daunting. Respondents shared feeling pressured, anxious, and a sense that every request is *"urgent"* while at the same time they described a lack of sufficient recognition of their needs. In addition, implementation of the MindShare system was delayed by nearly 2 years due to a number of issues, most significantly being difficulties in obtaining and importing data into the system.

Despite these challenges, the PQI team has continued to move forward, streamline processes, and are now producing reports and data analytics as originally envisioned. WMPC and private agency staff in Kent County continue to use MindShare (and other platforms) to report and monitor case data and trends. In the final year of data collection, private agency respondents reported an increased understanding of the data and how to produce analytic reports. Additionally, in Year 4 of the pilot, WMPC used predictive analytics to identify (1) children at high risk of MIC, and (2) the likelihood of achieving permanency within 1 year, so that services and resources can be allocated more effectively. Throughout the pilot, respondents have questioned the reliability of the data; at the close of the evaluation, WMPC was in the process of creating a position focused on data quality.

Overall, in the fifth year of the evaluation, the majority of private agency respondents reported support for WMPC PQI efforts. Nearly all of the private agencies have created specific staff positions that focus on PQI, data, and utilization management. Several private agency staff reported that the WMPC PQI meetings provide an important feedback mechanism that works in conjunction with their own agency quality improvement teams. Respondents reported that WMPC shares data with agency staff on a monthly and quarterly basis (for different types of data), and that the data is comparable to what an agency tracks within their own data systems as well as to monthly reports MDHHS receives. Some private agency staff reported the benefit of cross-agency data comparisons, sharing that through the newly rolled out quarterly report format, all private agencies participate at the same time and can make comparisons of key performance indicators across the five private agencies. According to the respondents, the new format facilitated collaboration between the private agencies and cross-agency learning. Other respondents reported the value of having data that is transparent, accessible, and presented in a visually appealing format. Still others valued being able to view data trends on intake and discharges and described how the data helps inform budgets, or they valued the ability to track EFC data (MiSACWIS does not track this data).

Several WMPC respondents reported an awareness that despite their efforts to be more *"action oriented"* in the presentation of quarterly data, it was sometimes a challenge to present data in a way that is best understood and able to be operationalized by agencies into potential practice changes. This was especially true beyond the director or manager level. Respondents from at least one private agency reported that WMPC provides data, but at times it can seem repetitive or redundant of data they receive from their own agency staff, data sent by the MDHHS data analyst, or data from MDHHS' Division of Child Welfare Licensing State compliance audits that result in a corrective action plan. A few respondents reported that they looked to WMPC to emphasize more of a solution focus along with data on key performance indicators. One agency respondent reported

that the statistical reports and predicative analytics from WMPC were more confirmatory than new information and struggled to see how understanding the data directly impacts and informs practice.

3.3.5.1 Utilization Management

One substantial shift in Year 2 of implementation was the move to a fully integrated utilization management program focused on achieving permanency within 12 months by managing residential utilization and EFC services. The utilization framework was rolled out in May 2019 and became increasingly important during Year 3 of implementation in part due to the ongoing financial deficits WMPC experienced. The utilization management approach is designed to improve financial management and efficacious use of services, described by interview and focus group respondents as essential for sustainability. At the end of the evaluation period, WMPC was in the early stages of implementing a new Clinical Utilization Manager position, developed as a result of an agency-wide analysis that identified utilization management as the *"center point"* between PQI and care coordination.

Research Question: What factors facilitate and inhibit effective implementation of child welfare practice, in general, and, importantly, the Kent Model (in Kent County)?

3.3.6 Kent Model Effectiveness

As mentioned in Section 2.5.1, in May 2022 the process study team conducted interviews and focus groups with leaders and supervisors from Kent County DHHS and private agencies, as well as WMPC and MDHHS leadership. As these child welfare stakeholders reflected on Kent Model implementation since it launched in 2017, they identified elements or factors that helped agency staff support families with children in care most effectively, elements or factors that made it more difficult to serve families effectively, and their perceptions of factors that may influence certain outcomes. A summary of this information is provided in the sections that follow.

3.3.6.1 Facilitators to Implementation

Representatives from Kent County DHHS, all five private agencies, and WMPC identified **EFC** as the most important initiative that was introduced during the pilot. Respondents indicated that EFC helps agency staff meet the needs of the families they serve, and they used terms and phrases such as *"impactful," "super helpful,"* and *"biggest success"* to describe EFC.

> ***"Enhanced foster care is such a unique approach in this pilot and is probably the absolute best thing that has come out of it."***
>
> –Agency leader

Another aspect of the Kent Model that respondents from all agencies and WMPC identified as being most important in helping agency staff meet clients' needs is the **funding flexibility** and the ability of agency staff to **apply creativity to case planning.** For example, one agency leader emphasized that *"the flexible approach to funding and service delivery, the nimbleness of the pilot, if you will, and really being creative around services that kids and families need…is extremely important in child welfare work."* A supervisor found the flexibility helpful when trying to maintain placements, especially for children with extensive needs. Respondents from multiple agencies also identified other important features of the pilot, which are listed in Exhibit 3-1.

Exhibit 3-1. Other important features of the pilot that respondents identified

WMPC's structure and operation, with respondents stating that they appreciate organization representatives' care coordination services, support and guidance, increased oversight of private agency activities, and their *"teamwork approach"* to problem-solving.

Increased **collaboration and coordination** among private agencies and between private agencies and WMPC, as some respondents observed a shift from *"competing against each other"* and working in silos to working *"much more closely together."* Some respondents also found it helpful that WMPC facilitates collaboration among private agencies and with partner agencies (e.g., Network180), while others stated that simply being involved in the pilot prompted them to increase engagement with other agencies because they are all working to achieve the same goals.

Having the **higher case rate** afforded agencies the ability to increase the daily rate for foster care providers and hire needed agency staff.

Increased **ability to obtain internal approvals** for funding from agency leaders, so agency staff do not *"lose time waiting"* for requests to be approved externally.

Getting ***"quick responses"* to requests for funding,** enabling families to begin receiving services as soon as possible.

The emphasis on **data-driven decision-making** and WMPC's support in helping agency staff connect activities to outcomes. Respondents from multiple agencies stated that their accountability and data tracking have become more prominent during the pilot because WMPC is implementing a *performance-based* funding model, and it is essential to understand *"why numbers are the way they are and then how to improve them."*

3.3.6.2 Barriers to Implementation

Although interview and focus group respondents identified many elements of the Kent Model that facilitated their efforts to serve families effectively, there were several factors that were barriers to effective service delivery during the pilot. Respondents from several agencies discussed the challenges that staff turnover presents. Although some respondents discussed turnover among WMPC staff specifically, they also acknowledged that turnover is not isolated to WMPC; it is a longstanding issue in child welfare. However, one component of the pilot that agency staff described in positive terms is having a single point of contact from WMPC who supports staff in their agency. Agency staff build rapport with the point of contact and then will have to establish a relationship with a new WMPC representative due to turnover. As one supervisor explained, *"You start to get used to the style of a specific person in a role or they start to become familiar with your processes or your cases, and then they're gone."* Some respondents also noted that turnover among state- and county-level agency leaders makes it difficult to *"continue processes and make sure everything is being followed through."* Respondents from several agencies also described another theme that has emerged consistently over time—limited availability of services for their clients. One respondent attributed long waitlists to staff shortages at partner agencies, which is likely due to turnover.

> ***"Some of that really good point person consistency [from WMPC], we've lost that again. So it was helpful, but it's not sustainable if you can't keep the same people in those positions."***
>
> –Agency supervisor

Respondents from two different agencies described misalignment between their expectations for collaboration with WMPC and among agencies, and the extent to which agency/organizational staff actually work collaboratively. For example, some respondents stated although one of the objectives of the pilot was to serve families in Kent County more effectively through collaborative partnerships with WMPC, the quality of the partnerships has changed over time. Some agency staff stated that interactions have *"become very compliance driven"* and that one-on-one contact has steadily declined since the pilot began, particularly during the COVID-19 pandemic as staff became dispersed. Private agency staff found it helpful that WMPC staff invested time in *"getting to know our staff, [and] knowing our cases in and out,"* and stated that this level of familiarity no longer exists. As one respondent articulated, there was a shift from Care Coordinators being the *"heartbeat of WMPC"* who *"have an intimate knowledge of the case"* to focusing more on data-related issues with care coordination as an *"afterthought."* Relatedly, respondents from three agencies also stated that there is an inadequate level of communication. They expressed the need to increase communication among agencies and observed that effective interagency collaboration has declined in recent years.

> ***"We had someone [from WMPC] in the office once a week and now they can't really come to us because they don't even live near us."***
>
> –Agency supervisor

> ***"We're so focused on data that it's like we have to get these boxes checked, so we're losing the quality."***
>
> –Agency supervisor

Data-driven decisionmaking was described as an important facet of the pilot in Section 3.3.6.1. However, respondents from multiple agencies also expressed dissatisfaction with the extent to which and how data is used and interpreted, although their specific data-related concerns varied. For example, some respondents expressed concerns about the quality and accuracy of data that is tracked, and others were uncertain of the utility of MindShare, the data reporting platform in which WMPC made a substantial investment. Other respondents questioned how to define success overall for the pilot (e.g., *"Oakland and Ingham and other counties fared pretty well without any of this."*) and for child outcomes. For instance, keeping a child out of a residential facility is viewed as a *"victory,"* but a supervisor stated that hearing a child say, *"I want to go to residential because I don't want to keep being told every day that that family that had me last night doesn't want me anymore"* underscores the importance of understanding the story behind the numbers.

Other factors that respondents from multiple agencies identified as barriers to service provision through the pilot include:

- The WMPC adding ***"another layer"*** to collaborative structures that existed prior to the pilot. As one agency leader explained, *"It kind of just feels like another entity that we have to go to, like a middleman, essentially."*

- The **lack of clarity** about specific aspects of the pilot, such as requirements, processes, and roles. As one respondent explained, *"where something might be approved for [one child], when we try to get it approved for [a different child], it's denied. And there's really no guidelines of what the difference is."* Another respondent described struggling to *"understand what the role of the care coordinator is and how they can best walk alongside us as the private agencies."*

3.3.6.3 Influence on Permanency

Recent outcome study results show that children exit to permanency more quickly in Kent County than in comparison counties, at least during the first 12 months. The process study team asked child welfare agency leaders and supervisors in Kent County what factors, from their perspective, explain differences in outcome results.

Respondents from multiple agencies identified the following factors as having an influence on permanency:

- **Kent County's court system and judges.** Respondents stated that *"judges now seem to be more on board with agency recommendations,"* guardian ad litems and court representatives are *"a lot more collaborative"* in Kent County than in other counties, Kent County's court system is *"very efficient,"* and judges are *"very involved"* and *"more hands-on and ask specific questions."*

- **Flexible funding and creativity.** Respondents noted that WMPC is *"willing to help out with funding"* and accepts *"miscellaneous funding requests"* for services to facilitate reunification. Another respondent noted that prior to the pilot, agency staff could not recommend services or placements that fall outside of child welfare policy (e.g., placement with fictive kin). Now they have *"more flexibility and creativity"* to make decisions that are in the *"best interests of children."* One respondent noted that agencies have more flexibility "with how we use [the] Kent Reunification Program," through which families receive assistive support (e.g., family therapy) prior to and following reunification.[41]

- **Data-driven decisionmaking.** Some respondents attributed the differences in outcome results to Kent County's emphasis on data and utilization management. They explained that at regular intervals, WMPC Care Coordinators and private agency staff discuss the agency's cases and strategize about how to overcome barriers.

- **EFC.** One respondent who has worked in child welfare outside of Kent County hypothesized that *"maybe we would've gotten kids to permanency sooner [in another county] instead of having to move placements or seek out those services for replacement"* if EFC had been available. Another respondent stated that *"EFC can be in place for reunification, for guardianship, for adoption, for all of our goals"* and concluded that *"EFC has played a huge part in permanency."*

- **Availability of resources.** One respondent noted that as a smaller county, Kent County has an *"abundance of resources available to us than some of the surrounding counties that we work with."* Another respondent from a different agency stated that *"Kent County is an extremely rich service county,"* which may enable families in the county to obtain the support needed to achieve permanency faster than in other counties.

3.3.7 Interagency Collaboration After the Kent Model Ends

Prior to Kent Model implementation, private agency interactions were with Kent County DHHS. As discussed in this and prior annual Kent Model evaluation reports, interview and focus group respondents described having limited interactions with staff from Kent County DHHS, as most

[41] https://www.wmpc.care/what-you-should-know/become-a-provider/

case-related communication and interactions occur with WMPC. As the MDHHS-funded pilot period nears completion, interview and focus group respondents described their expectations for interactions among Kent County DHHS, private agencies, and WMPC. Regardless of whether private agency staff partner with Kent County DHHS or WMPC, respondents from nearly all private agencies reported that they strongly support continuation of EFC because of how beneficial its services are for families with children in care.

3.3.7.1 Kent County DHHS and Private Agencies

Respondents from two different private agencies emphasized the importance of having collaborative relationships with staff at Kent County DHHS. They acknowledged the role Kent County DHHS plays, as the entity that makes decisions aligned with state and county policies, but they would appreciate having more opportunities to engage in shared decisionmaking with Kent County DHHS staff. Respondents also mentioned the value of having face-to-face contact (e.g., as opposed to contact being limited to email) with main points of contact at Kent County DHHS to build and maintain rapport. Relatedly, some respondents from private agencies appreciate having one WMPC Care Coordinator assigned to their agency, as opposed to multiple Kent County DHHS monitors assigned to one agency prior to the pilot.

> ***"The less* [sic] *people that you have to deal with in terms of getting things approved, the easier it is. Because when you're dealing with 20 different people, they all have different expectations, no matter what the policy is."***
>
> –Agency leader

Respondents from Kent County DHHS and the private agencies concurred that it will be essential to begin *"rebuilding those relationships"* as the agency staff reestablish partnerships. One respondent seeks to avoid the *"private agency versus DHHS"* approach to child welfare and forge true collaborative partnerships.

3.3.7.2 WMPC

There are several elements of WMPC that private agency staff would like to increase or maintain after the pilot ends. Interview and focus group respondents from nearly all the private agencies reported that they appreciate WMPC's flexibility around funding for services and exchanging ideas with Care Coordinators to identify creative solutions to case challenges. One respondent suggested that *"there's less red tape when we need additional items for a home or something."* Respondents also discussed the need for more support from WMPC. Some respondents observed a shift in their relationships with Care Coordinators since the pilot began. One supervisor stated that Care Coordinators were *"super helpful"* and *"weren't going to judge"* any questions agency staff posed at the beginning of the pilot, and noted that relationships have not been as collaborative as of late. Another respondent from a different agency echoed this sentiment, attributing the shift to a different group of Care Coordinators who may not have received the same messaging about their role, *"to support and coordinate and supervise your private agency."*

> ***"I think just the flexibility and the humanity that WMPC brings to us…it's made our lives so much nicer. We can actually get the things that we need for our clients. They actually see our clients as people rather than just a case or a number on a paper."***
>
> –Agency supervisor

3.3.8 Lessons Learned

The process study team asked interview and focus group respondents from MDHHS, WMPC, Kent County DHHS, and the five private agencies to reflect on the intricacies of pilot implementation and consider the lessons they learned during the pilot period. If a performance-based funding model were to be implemented in another state or Michigan county in the future, what advice or recommendations would they give to representatives who will be involved with the pilot? A summary of major themes that emerged is provided below.

3.3.8.1 Recommendations for Organizations Implementing a Performance-Based Model

Most of the recommendations respondents provided during interviews and focus groups apply to an entity like WMPC that will implement a similar funding model (referred to as "the organization" for the remaining parts in this section, 3.3.8.1). Respondents recommended that the entity:

1. **Establish and maintain effective collaborative relationships.** Respondents emphasized the importance of the organization establishing collaborative relationships with agency staff beginning when the funding model launches and continuing throughout implementation. This expectation should be communicated to all of the organization's staff, particularly when there is a lot of turnover and the organization hires new staff. Several respondents also commented on how collaboration and relationships changed during the pandemic when more staff began working virtually. Strong relationships should be nurtured, regardless of how interaction occurs (in person or virtually). One supervisor stated that rather commanding a hierarchical relationship with private agency staff, the organization and private agency staff should keep in mind that they are *"in it together"* and *"walking this path together."*

> ***"I think helping them remember to keep teaming and collaboration as the number one priority and everything else kind of comes after that, and that's how you can build a good team."***
>
> –Agency supervisor

2. **Ensure all organization staff is based in the community where the model is implemented.** Some respondents expressed frustration that WMPC staff with whom they interact are located outside Michigan. They underscored the importance of organization staff having a presence in the community, being accessible to agency staff (e.g., some respondents prefer to meet with WMPC staff in person), and maintaining an understanding of community characteristics and context. One respondent explained, *"I would like to see them locally based and more accessible and really have their finger on the pulse of what is really happening in this community."*

3. **Recruit appropriate staff, consultants, and leaders.** Some respondents observed that some WMPC staff are overextended and playing multiple roles to fill gaps. They suggested increasing efforts to hire adequate staff so all staff can do their job effectively. Some respondents recommended that the organization hire experienced and flexible staff with specific expertise (e.g., one respondent suggested hiring PQI staff while another respondent suggested hiring staff who have experience with startup organizations). Additionally, a few respondents discussed WMPC's board of directors. Reactions were mixed regarding whether representatives from provider agencies should be on the board. Organization planners should

determine if it would be advantageous to include these representatives on the board as they *"understand all of the pieces"* of the model, or if the board should be composed of representatives who are not affiliated with a provider agency that holds a contract with WMPC (or a mix of providers and non-providers). One respondent stated that *"there has to be some independent-minded people on the board"* to avoid *"a really big conflict [of interest]."*[42]

4. **Maintain active engagement with agency staff.** Some respondents from private agencies underscored the importance of organization representatives having direct contact with agency staff. For example, one respondent stated that organization representatives should *"make sure their camera is on and their mic is on"* and *"assert themselves"* in virtual meetings, while another respondent values *"the communication and the connections with people, meeting with people face to face, knowing who each other are outside of an email."* Other respondents recommended seeking feedback from agency staff prior to and during performance-based model implementation, and articulate roles and expectations early on. For example, one respondent suggested that organization representatives include input from agency staff with experience on the ground during the model planning phase, stating:

> ***"I think it's important [for organization and agency representatives] to have connections and build rapport, just like we would do with clients."***
>
> –Agency supervisor

> *I would just recommend…that they do workgroups that have not just supervisors, directors, vice presidents in it, but that they're doing staff work groups so that they really hear from the staff about what they need to continue to be successful or to do their jobs better.*

One respondent specified that while the role and responsibilities of child welfare agency positions are easily understood (e.g., Licensing Worker), those for staff in an organization like WMPC (e.g., Care Coordinator) are open to multiple interpretations. It may help for the organization to provide agency staff with *"clear roles and job descriptions"* so there is shared understanding of how staff from the organization and provider agencies will collaborate. Other interview and focus group respondents recommended organization representatives communicate regularly with agency staff about their needs and expectations. For example, one respondent described WMPC applying for and receiving grants and expecting agencies to participate without asking *"if that's something that the agencies in Kent County wanted or if that would even be helpful to them."* Another respondent recommended that the organization seek feedback from agency staff about changing contract expectations before they are finalized to ensure *"the expectations are reasonable and achievable."*

[42] The current WMPC board of directors is composed of representatives from private provider agencies and community organizations (https://www.wmpc.care/about/our-board-of-directors/).

3.3.8.2 Recommendations for State Agencies

In addition to providing recommendations for organizations that would have a role similar to WMPC in implementation of a performance-based funding model in a different state or Michigan county, several themes emerged from interviews and focus groups about recommendations for state DHHS agency leaders that will fund and oversee a performance-based model (Table 3-18) and local provider agency directors (Table 3-19).

Table 3-18. Recommendations for state DHHS agencies

Recommendations	Additional information
✓ Outline and communicate expectations for the model	• Be explicit about the goals for the model • Define the model's purpose so it is clear how funds are to be expended *"So performance-based funding. What are you talking about? What does that mean? What is the performance we're looking for?"*
✓ Support model implementation	• Advocate for the model to facilitate buy-in from the state level and throughout the county in which implementation is occurring *"In terms of it being more supported, it really needs to come from the top down consistently."*
✓ Enable county agencies to have control	• Provide county agencies with the decision-making authority that the implementing organization would have *"Do performance-based funding. Have the flexible funding. But eliminate all the administrative costs of creating a whole new agency to do the administration of the funding."*

Table 3-19. Recommendations for private agency directors

Recommendations	Additional information
✓ Clarify and define roles and expectations	• Define staff roles and expectations for each partnering agency • Document processes, roles, and responsibilities *"That's what I would suggest is when you're meeting, you're always knowing who does what, what is that role, what are the expectations, and what do they expect from us."*
✓ Support model implementation	• Communicate to staff about model-related activities in positive terms • Facilitate understanding among staff of the purpose of the model and support its implementation *"I think just getting that excitement from people, you have to get them excited about it and have them feel connected to its purpose."*
✓ Build and maintain collaborative relationships	• Strengthen relationships with individuals who make decisions for the model, and advocate on behalf of the agency • Maintain collaborative partnerships with other private agencies *"I think it's important to form those relationships early to develop those collaborative relationships, not just with the WMPC, but the other agencies doing the work and learn from each other.""*

Ingham and Oakland Counties

As mentioned in Section 1.2, Ingham and Oakland counties serve as the comparison counties for the process evaluation. The process study team conducted interviews and focus groups with agency staff and partners in these counties over the course of the 6-year evaluation. Agency staff in these two comparison counties as well as Kent County described similar experiences related to some topics, such as the barriers related to frequent staff turnover (e.g., increased workloads) and strengths and challenges to partnering with mental health agencies and the court system (e.g., waiting lists for mental health services, caseworker training to prepare for court hearings). However, the experiences of agency staff in the comparison counties diverged from those of agency staff in Kent County relative to service approval, service availability, and collaboration with the county DHHS agency. These topics are described in the sections below.

3.3.9 Service Approval and Availability

Service approval process. Private agency staff and leaders in comparison counties reported that the service approval process can take a considerable amount of time. Delays are often due to communication issues, type and cost of service requested, incomplete information provided to the county DHHS agency, and a multi-layered approval process. Private agency staff noted that some county DHHS representatives responsible for reviewing service requests approve them faster than others. Some services, such as trauma assessments, may take more time to approve because they are expensive and often require a court order. For some service requests, caseworkers must obtain supervisor approval before sending the request to DHHS for approval, which can contribute to delays in obtaining approvals. DHHS staff noted that service requests from private agencies sometimes lack essential information. Obtaining the information can contribute to approval delays.

While lengthy service approval processes were a persistent theme among respondents from comparison counties for most of the evaluation, the opposite was true among agency staff in Kent County. For the most part, WMPC expedited these processes. However, in 2021, interview and focus group respondents in Kent, Ingham, and Oakland counties described the service approval process in positive terms. The COVID-19 pandemic prompted state, county, and agency leaders to make policy and procedural changes to enable staff to serve clients while adhering to public safety guidelines. It is possible that the changes, such as increased use of electronic signatures, remote work, and virtual meetings, increased efficiency across private and public agencies and facilitated a more seamless service approval process.

Service availability. Agency staff from all three counties expressed frustration with limited availability of some services for clients (e.g., mental health services, substance use screening), with one respondent stating, *"We need more services, always and forever."* There are often waiting lists for certain services, there is an inadequate number of providers offering some needed services, and agency staff often have difficulty locating services that are necessary to meet a family's needs. Although agency staff across counties discussed these challenges, some services are available to families in Kent County as a result of the pilot (e.g., EFC). The implication is that although service availability is a common challenge in all three counties, families in Kent County have benefited from having access to support services they may not have received if it were not for the Kent Model.

3.3.10 Collaboration with DHHS

Interactions between agency staff in private agencies and the county DHHS agency vary between Kent County and the comparison counties due to the existence of WMPC in Kent County. As mentioned in Section 3.3.4.1, private and public agency staff in Kent County have limited interactions given that the WMPC serves as the *"middleman."* In Ingham and Oakland counties, as well as other counties in Michigan that function through the per diem model, private agency staff must engage frequently with staff from the county DHHS agency as part of case practice (e.g., to seek approval for service requests). Overall, respondents from private and public agencies in the comparison counties described their relationships as collaborative and collegial. Respondents identified a number of factors that facilitated the positive interactions, including:

- Open lines of communication,
- Responsiveness,
- Positive rapport and trust,
- Regularly scheduled inter-agency leadership meetings,
- Inter-agency trainings, and
- Long tenure of staff at DHHS.

Throughout the evaluation, private agency staff in Ingham and Oakland counties also described challenges to collaborating with DHHS staff. They often experienced communication issues, perceived that there was a lack of support from DHHS staff (e.g., *"Sometimes it very much feels like us against them or them against us."*), and often disagreed on family goals. Respondents from county DHHS agencies described difficulties engaging with staff from multiple agencies that all have different policies and procedures, frustration with how cases are assigned (e.g., respondents that stated that cases that private agency staff decline must be managed by a DHHS caseworker), and frequent turnover in private agencies prompting additional DHHS oversight to ensure expectations are met.

3.3.11 Summary of the Process Study

Over the past 6 years of the Kent Model evaluation, the process study team has conducted interviews and focus groups with a range of child welfare agency staff and leaders from Kent, Ingham, and Oakland counties, as well as MDHHS leaders and partner agency providers. These data collection activities have enabled the study team to obtain multiple stakeholder perspectives on child welfare case practices, intra- and interagency collaborative strategies, and similarities and differences in policies and practices among agencies in Kent County and the comparison counties (Ingham and Oakland). Interviews and focus groups with Kent County and MDHHS stakeholders included discussions about Kent Model implementation.

Early on in the evaluation, several themes emerged during discussions that remained consistent over time. For example, turnover within child welfare and partner agencies has been a persistent challenge in all three counties (and in child welfare overall), which was exacerbated by the COVID-19 pandemic. Although agency staff welcomed some pandemic-related changes (e.g., remote work with increased flexibility, virtual court hearings and family team meetings), some respondents

experienced increased stress due to factors such as reduced opportunities for peer contact and support and limited availability of services that address child and family needs. Additionally, respondents in Kent County have provided overwhelmingly positive feedback about EFC ever since it became a service option to support children with high needs.

Over time, private agency staff in Kent County expressed mixed feelings about WMPC's utility. WMPC adds or adjusts organization positions when necessary to better address agency staff and families' needs, provides a single point of contact for care coordination services, and liaises between the private agencies and Kent County DHHS. WMPC has experienced a lot of turnover, which has been challenging for staff in the private agencies (e.g., who depend on Care Coordinators for support) and WMPC (e.g., limits their ability to strategize and innovate). Private agency staff also expressed frustration that WMPC staff assigned to support their agency were located outside of the local community, as they emphasized the importance of being physically present in Kent County to maintain first-hand knowledge of the local context for service provision and be more accessible to staff.

During the last wave of data collection for the evaluation, the process study team conducted interviews and focus groups with agency leaders and supervisors in Kent County DHHS and the private agencies who had been at their agency since the pilot began in 2017. The study team also interviewed MDHHS leaders responsible for overseeing pilot implementation and progress. These stakeholders reflected on their experiences with the pilot and shared lessons learned. In addition to EFC, across agencies, respondents agreed that facilitators to implementation included funding flexibility and having the ability to identify creative solutions during case planning. However, barriers such as high turnover and limited service availability stymied their ability to effectively serve families with children in care.

Child welfare stakeholders in Kent County who had been at their agency since inception of the pilot observed and described the ways in which child welfare policies and practices changed during Kent Model implementation. They identified services, processes, and structures that they would recommend maintaining, such as EFC, funding flexibility, and care coordination, as well as those they would improve, such as data reporting and extraction processes, and communication practices (e.g., providing clarity on expectations related to new services or programs to be implemented).

4. Summary and Conclusions

Summary

MDHHS contracted with Westat and its partners, Chapin Hall and University of Michigan School of Social Work, to conduct an evaluation of the Kent Model. Through the evaluation, the study team examined the extent to which and how Kent Model implementation leads to positive outcomes for families with children in care as a result of more flexible and efficient service provision. The 6-year evaluation enabled the study team to examine changes in **costs** associated with the Kent Model, **outcomes** for children in care (safety, permanency, and stability), and agency and staff **processes** for supporting and engaging in effective case practice. Evaluation results revealed strengths and weaknesses of the Kent Model, which have been summarized in this report.

Overall, total private agency expenditures in Kent County increased from the pre-implementation period (FYs 2015-2017) through the first 2 years of the pilot (FYs 2018-2019) before decreasing in FY 2020 through the end of the evaluation (FY 2022). Private agency expenditure trends in the county are driven by placement costs, as nearly all expenditures are related to placement maintenance and administration. In Kent County and across the state, CCIs composed the largest proportion of placement expenditures. Expenditure decreases were largely due to a decline in the number of children entering care and decreased care day utilizations, particularly between FYs 2019 and 2020, with continued decreases through FY 2022. The pandemic led to substantial changes in how child welfare and partner agency staff served families with children in care. Interview and focus group respondents described statewide reductions in the availability of residential care coupled with increased children's needs due to the COVID-19 pandemic. Respondents perceived that a higher level of need led to increased demand for EFC services. Relatedly, cost study results indicate that utilization of EFC care days increased over the past 3 years, while utilization of congregate care declined from 12 percent of total care days in FY 2018 to 6 percent in FY 2022. At the same time, the overall average daily cost of providing care increased during the first 2-year pilot, then started decreasing in FY 2020 returning to pre-pilot levels in FY 2022. However, the size of the reduction in costs was tempered by higher-cost CCI placements. Even though fewer days were spent in congregate care, the cost of CCI placements increased by 44 percent during the pilot, offsetting some of the potential from shifting care days from CCI to EFC. Consequently, expanding EFC to children who would otherwise be in congregate care and assessing the approval process to ensure that children are placed in the lowest level of congregate care possible could reduce costs. The pandemic introduced new challenges to service provision, while prompting service providers to make adjustments that addressed shifting needs to facilitate foster care discharge.

The cost effectiveness analyses revealed that there was not a significant difference in the cost of achieving reunification, and a slightly higher cost of achieving adoption for children in Kent County compared to the matched group. These are the total maintenance and administrative costs accumulated during an out-of-home placement spell. The slightly higher cost of exiting to adoption can be linked to Kent County's higher average daily unit costs of care, and longer lengths of stay for children entering care during the first 2 years of the pilot. WMPC lowered costs in FY 2020, in part by decreasing the PAFC rate to state levels. Simultaneously, length of stay decreased for the FY 2020 entry cohort, contributing to lower costs per spell, but median duration increased again for the FY 2021 entry cohort, so these savings may not be sustained. WMPC could make strategic

investments to reduce length of stay. For example, the statewide Rapid Permanency initiative implemented in April 2020[43] may have contributed to the shorter durations observed for the FY 2020 entry cohort. Additionally, prospective payment models inherently incentivize reduced length of stay—compared to traditional fee-for-service models that may promote overutilization—because providers retain excess revenue when children reach permanency more quickly (see Appendix E).

However, neither of the prospective funding models used during the pilot provided WMPC with an appropriate level of revenue. The case rate model used for the first 3 years of the pilot fell short of actual expenditures, largely due to WMPC policies (e.g., higher PAFC administrative rates and paid kinship care). Beginning in FY 2021, the pilot switched to a capitated allocation model that greatly overfunded the pilot, in part due to a large decline in the number of children entering care. Moving forward, the cost study team recommends shifting to a prospective payment model that uses care day utilization and child placement trends to project the allocation amount (see Appendix E). The revised fiscal model could also create an incentive structure for providers to make investments in the quality and process of care with the goal of improving outcomes.

In addition to cost considerations for the Kent Model, the evaluation team assessed the extent to which there were differences between children in Kent County and the comparison counties relative to safety, permanency, and placement stability outcomes. There were no statistically significant differences between children in Kent County and the comparison group on outcomes related to safety (maltreatment recurrence and maltreatment in care) or placement stability. In terms of permanency, children in Kent County exited care at a higher rate and were in care fewer days than children in other Michigan counties. A significantly higher percentage of children in Kent County than in the comparison counties achieved permanency within 6 and 12 months of entering care. The differences were not significant among children who exited to permanency within 18 months, which leads to questions about factors that influence the rate at which children achieve permanency.

Agency staff who participated in interviews and focus groups as part of the process study speculated about factors, initiatives, or other activities in Kent County that may influence how quickly permanency is achieved. Some respondents who manage cases in multiple counties observed more collaboration and involvement from judges and other court system representatives with agency staff in Kent County than in other counties. They also observed that Kent County has more services and resources for families than in other counties. Agency staff also attributed differences between children in Kent County and comparison counties in how quickly they achieve permanency to increased flexibility around how caseworkers use funds to serve families. For example, one respondent expressed appreciation that WMPC accepts *"miscellaneous funding requests"* for services to facilitate reunification. Additionally, respondents noted WMPC's emphasis on data-driven decisionmaking. The organization integrated a utilization management system to improve financial management and efficacious use of services, and WMPC's Care Coordinators help agency staff strategize to increase effective case management. Furthermore, as mentioned throughout the report, agency staff in Kent County have strongly supported EFC since it became available, and interview and focus group respondents identified the service as a key contributor to positive permanency outcomes. These topics could be explored during a subsequent evaluation to estimate the extent to which each variable contributes to the rate at which children exit care to permanency.

[43] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

Outcome results imply that policy or practice changes made through the Kent Model had more of an effect on how quickly children achieved permanency at 6 and 12 months without compromising the safety of children. One explanation for these results could be that MDHHS and Michigan's State Court Administrative Office launched the Rapid Permanency Initiative in 2020 to expedite the reunification process during the COVID-19 pandemic.[44] However, it was a statewide initiative, and it is unclear if there was more emphasis on rapid reunification efforts in Kent County than in other counties (in addition to the Rapid Permanency Initiative). Because the difference of achieving permanency at a higher rate disappears at the 18th month mark, to innovate the project further, more investigation could be done to see why the difference disappears and for which children. Another difference found was that children in Kent County who exited to permanency exited to adoption at a lower rate than other permanency types. Depending on the preference of permanency types, the Kent Model may be a better model for increasing more exits to living with other relatives, guardianship, and reunification as opposed to adoption. More investigation may be needed in this area as well to confirm that it was in fact the Kent Model that can be attributed for this difference in exits to adoption.

Throughout the course of Kent Model implementation, representatives from WMPC, Kent County DHHS, and private agencies described beneficial changes associated with the Kent Model, implying that they would be considered successful aspects of the pilot:

- **EFC,** which agency staff and leaders described as the most important component of the Kent Model.
- Having a **single point of contact** for service approvals, case monitoring, guidance, and support.
- Having opportunities for staff to engage in inter-agency **collaboration** to share best practices and innovations.
- Having **flexibility** in how agency staff use funding and applying **creativity** to case planning.
- WMPC's application of a **utilization management approach,** to improve financial management and service efficacy.

Findings from the multi-year process study also revealed factors that impeded implementation (implication of less successful aspects of the pilot):

- **Staff turnover**, particularly among Care Coordinators whom private agency staff rely on for support and guidance.
- WMPC's **fiscal crisis,** which prompted adjustments in pilot management and administration.
- Care Coordinators being **located outside the community,** which private agency staff argued limited Coordinators' awareness of the local context for service provision and their accessibility to agency staff they support.
- Aspects of **data reporting and extraction** processes that made it difficult to accurately interpret and use data.

[44] https://www.michigan.gov/mdhhs/inside-mdhhs/newsroom/2020/04/28/mdhhs-and-courts-partner-to-return-children-home-from-foster-care-safely-during-covid-19-pandemic

WMPC leadership adjusted organization staffing structures and policies, when necessary, based on private agency needs, so that agency staff could address child and family needs more efficiently. As with any new initiative, hurdles are to be expected, as are new processes that may lead to positive outcomes. This report described barriers to Kent Model implementation that were balanced with the introduction of valuable new initiatives and processes. Relatedly, during the final round of data collection for the process study (with participation from Kent County agency staff who had been with the agency since the pilot began as well as MDHHS leadership), the study team asked interview and focus group respondents for one word they would use to describe the Kent Model (Exhibit 4-1). The responses were mixed—some words were positive and others gave the impression that respondents would do things differently if given the opportunity. The most commonly used Kent Model descriptors were *"creative"* and *"collaborative"* followed by words such as *"disappointing"* and *"underwhelming."*

Exhibit 4-1. Words used to describe the Kent Model

Conclusions

Overall, results for continuation of the initiative as a whole were inconclusive. The evaluation team recommends continuation of some components, while revising other components of the Kent Model. The Kent Model, like other programs and initiatives, has many different components that were implemented with varying levels of success. Additionally, the COVID-19 pandemic was an unprecedented event that occurred during Kent Model implementation. The pandemic led to unplanned disruptions and prompted immediate adjustments to how services were delivered. For these reasons, it is difficult to make an overall statement regarding Kent Model effectiveness. However, although evaluation results were mixed, some of the results uncovered promising policies and practices, which offers evidence of Kent Model strengths as well as areas for improvement.

The case rate model used for the first 3 years of the pilot fell short of actual expenditures, while the capitated allocation model led to a considerable surplus. Reviewing these results in isolation could lead to questions about WMPC over- or underspending. However, as indicated in the summary of cost study results, WMPC expended a substantial amount of funding in the first 3 years of the pilot to implement new policies that support case practice. For example, paid kinship care was implemented in Kent County before the rest of the state and agency staff are encouraged to place children with kinship providers as part of the Kent Model, which increased overall expenditures in the first 2 years of the pilot due to increased payments to kinship providers (challenge). However,

increased kinship care helped reduce the number of days children spent in more restrictive settings (strength). Additionally, the overall average daily unit costs of care are higher in Kent County than the rest of the state, partly due to a high level of CCI placements (challenge), but EFC use, which is intended to provide a less restrictive and lower cost alternative to CCI, increased during the pilot (strength). Therefore, as mentioned previously, the evaluation team suggests expanding EFC and placing children in the lowest level of congregate care possible to reduce costs. Additionally, revising the prospective payment model by using care day utilization and child placement trends to project the allocation amount may provide WMPC with revenue closer to actual child serving needs, while incentivizing providers to improve outcomes (see Appendix E).

The evaluation team also determined the extent to which changes made in Kent County through the pilot improved safety, permanency, and placement stability outcomes. The outcome study team found that outcomes for children in Kent County were similar to or better than those for children in the comparison counties; outcomes did not decline as a result of the pilot (strength). Specifically, the Kent County and comparison groups were similar relative to safety and placement stability, while overall, children in Kent County had more positive permanency outcomes than children in the comparison counties. Process study results were mixed—some policies and practices were described as Kent Model strengths (e.g., EFC, having a single point of contact for agency support and guidance), while others made implementation more challenging (e.g., WMPC staff located outside of Kent County, inconsistent data use and interpretation).

Evaluation results from the cost, outcome, and process studies revealed several strengths and weaknesses of the Kent Model. As mentioned earlier in this section, outcomes for children in Kent County were similar to or better than outcomes for children in the comparison group. Additionally, WMPC faced fiscal challenges but pivoted to identify strategies for supporting private agency staff needs and managing financial obligations. WMPC implemented policies and procedures that were intended to help agency staff serve children in care more effectively. Some were strongly supported while others were described as impeding service delivery. Taken together, evaluation results imply that it is appropriate to maintain ***components*** of the Kent Model. For example, EFC helped agency staff serve families with children in care more effectively and reduced time in more costly placement settings (e.g., CCI). Neither funding model (case rate or capitated allocation) provided WMPC with an appropriate level of revenue, leading the cost study team to recommend a prospective payment model that uses care day utilization and child placement trends to project the allocation amount (see Appendix E). The revised fiscal model could also create an incentive structure for providers to make investments in the quality and process of care with the goal of improving outcomes. The evaluation team suggests modifying or eliminating Kent Model components that were barriers to service delivery (e.g., policies regarding how data is used and interpreted to improve the quality and accuracy of data used to improve case practice). As mentioned earlier, in a subsequent evaluation, MDHHS may benefit from further exploration of factors that contribute to outcomes (e.g., the rate at which children exit care to permanency and the permanency type to which they exit, such as adoption or reunification).

References

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Appendix A

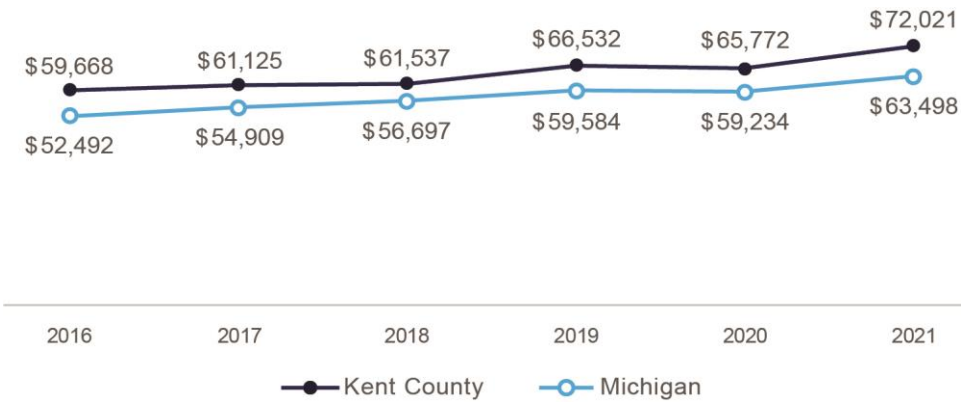
State and County Characteristics

Appendix A
State and County Characteristics

Kent County is located in western Michigan's lower peninsula and comprises 21 townships, five villages, and nine cities. Grand Rapids is the county seat and the second largest city in Michigan, with 775.1 individuals per square mile.[45] Over the course of the evaluation, Kent County's population ranged from 643,858 to 658,046.

The median household income for Kent County exceeded the state's median income between 2016 and 2021 (Figure A-1).

Figure A-1. Median household income



Source: https://www.census.gov/

The percentage of Kent County's residents who are White or Hispanic is higher than the state average for these racial groups, while the average percentage of Black residents for the state is higher than the average in Kent County. Additionally, the state average of households living in poverty is higher than Kent County's average (Table A-1).

[45] https://www.census.gov/quickfacts

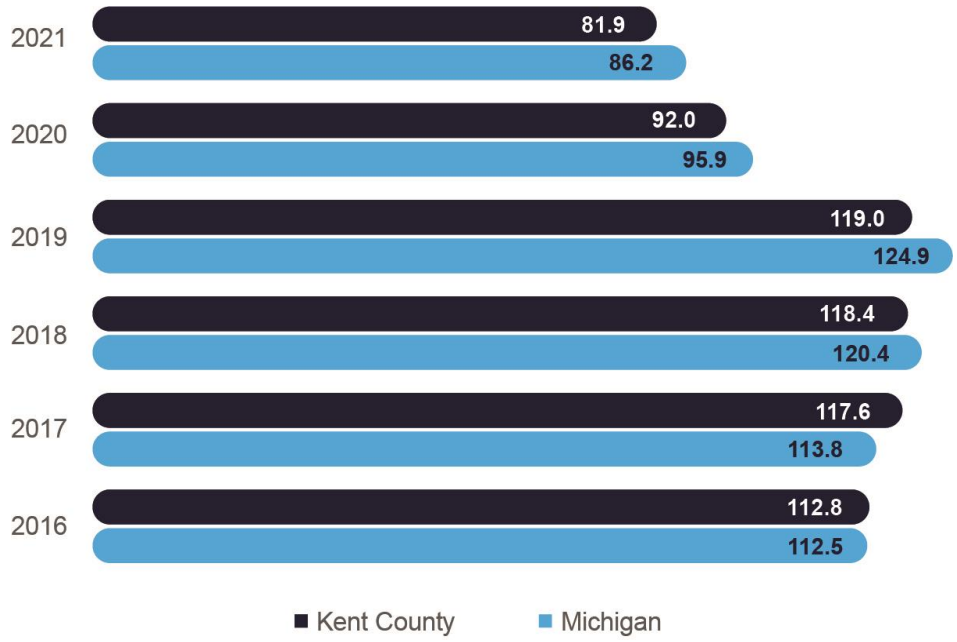
Table A-1. Demographic characteristics						
	2016	2017	2018	2019	2020	2021
Racial group						
White, not Hispanic or Latino						
Kent County	83%	83%	82%	82%	82%	82%
Michigan	80%	79%	79%	79%	79%	79%
Black or African American						
Kent County	10%	11%	11%	11%	11%	11%
Michigan	14%	14%	14%	14%	14%	14%
Hispanic or Latino						
Kent County	10%	11%	11%	11%	11%	11%
Michigan	5%	5%	5%	5%	5%	6%
Asian						
Kent County	3%	3%	3%	3%	3%	3%
Michigan	3%	3%	3%	3%	3%	3%
American Indian and Alaska Native						
Kent County	<1%	<1%	<1%	<1%	<1%	<1%
Michigan	<1%	<1%	<1%	<1%	<1%	<1%
Native Hawaiian and Other Pacific Islander						
Kent County	<1%	<1%	<1%	<1%	<1%	<1%
Michigan	<1%	<1%	<1%	<1%	<1%	<1%
Two or more races						
Kent County	3%	3%	3%	3%	3%	3%
Michigan	2%	2%	2%	3%	3%	3%
Other characteristics						
Persons in poverty						
Kent County	12%	10%	11%	11%	11%	10%
Michigan	15%	14%	14%	13%	14%	13%
Persons under 18 years						
Kent County	25%	24%	24%	24%	24%	24%
Michigan	22%	22%	22%	21%	22%	21%

Source: https://www.census.gov/

Statewide, nearly one quarter of the population is under 18 years old (Table A-1). When comparing child safety rates for the state and Kent County, the rates are lower in Kent County starting in

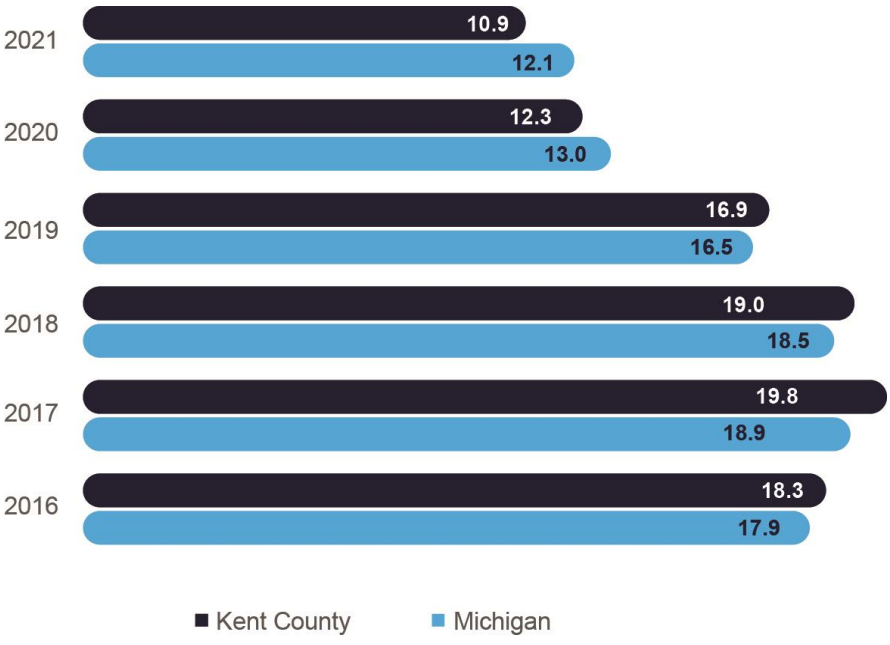
- 2018 for investigations (Figure A-2),
- 2020 for confirmed cases of abuse and/or neglect (Figure A-3), and
- 2017 for out-of-home care (Figure A-4).

Figure A-2. Rates of children in investigated families, per 1,000 children ages 0-17



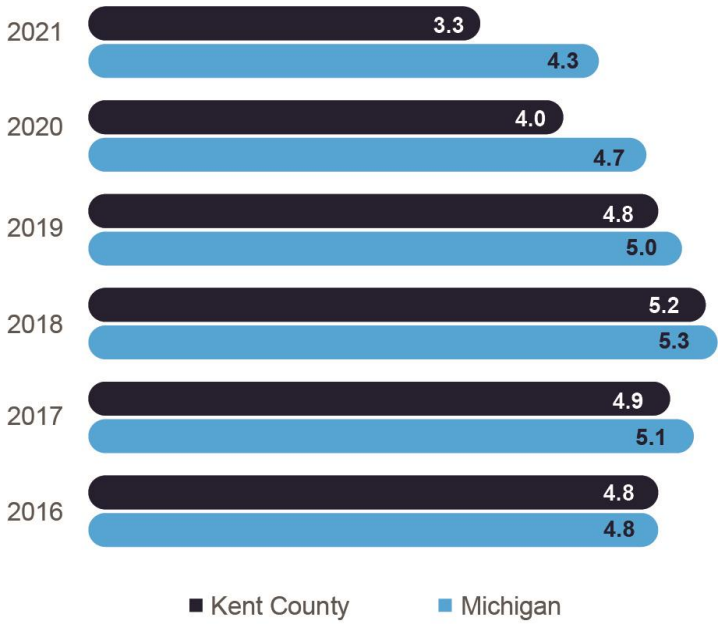
Source: https://datacenter.kidscount.org/

Figure A-3. Confirmed victims of abuse and/or neglect, per 1,000 children ages 0-17



Source: https://datacenter.kidscount.org/

Figure A-4. Rates of children in out-of-home care, per 1,000 children ages 0-17



Source: https://datacenter.kidscount.org/

Appendix B

Evaluation Plan

Summary: Evaluation Plan				
Research Question	**Subquestions**	**Indicator**	**Method**	**Source**
Process Evaluation				
Do the counties adhere to the state's guiding principles in performing child welfare practice?		• Fidelity of implementation to the MiTEAM practice model among caseworkers in Kent County • Kent County client reports of satisfaction with agency services • Quality of services caseworkers provided in Kent, Ingham, and Oakland counties	• Calculate the percentage of sampled cases for which services were provided in accordance with MiTEAM competency standards • Calculate the percentage of clients who reported they were satisfied with the services they received from the agency • Review findings from quality services reviews (QSR) on the quality of case practice • Obtain information about preparation for and implementation of the practice model and fidelity assessments (e.g., training, tools, monitoring)	• MiTEAM Fidelity Data Reports (quarterly) • Family satisfaction surveys (annually) • QSR reports (every 3 years) • Interviews and focus groups with caseworkers, supervisors, agency leaders (annually)
What resources (strategies, infrastructure) are necessary to support the successful delivery of child welfare services?	What resources (strategies, infrastructure) are necessary to support the successful implementation of the Kent Model?	• Availability of community-based services • Agency infrastructure • Ability to enter and use data effectively	• Obtain information on interagency partnerships (e.g., services provided, quality of relationships) • Obtain information of data management processes and systems (e.g., MiSACWIS, data accessibility)	• Interviews and focus groups with caseworkers, supervisors, agency leaders, key stakeholders (annually); agency documents (ongoing)
What factors facilitate and inhibit effective implementation of child welfare practice, in general, and importantly, the Kent Model (in Kent County)?	What factors facilitate and inhibit effective implementation of the Kent Model?	• Availability of community-based services • Agency infrastructure • Ability to enter and use data effectively	• Obtain information on interagency partnerships (e.g., services provided, quality of relationship) • Obtain information of data management processes and systems (e.g., MiSACWIS, data accessibility)	• Interviews and focus groups with caseworkers, supervisors, agency leaders, key stakeholders (annually); agency documents (ongoing)

Summary: Evaluation Plan				
Research Question	**Subquestions**	**Indicator**	**Method**	**Source**
Cost Study				
What effect has the transition to the Kent Model had on expenditure and revenue patterns in the county?		• The total annual costs in Kent by service domain, category, and description to pay for the full cost of services provided to children in out-of-home care and their families to support stable transition into a permanent home. • The total annual revenue in Kent County applied to costs to pay for the full cost of services provided to children in out-of-home care and their families to support stable transition into a permanent home. • The average annual daily unit cost of out-of-home placement in Kent County.	• Categorize spending patterns in the fiscal data by state Fiscal Year and service and placement type • Categorize revenue patterns in the fiscal data by state Fiscal Year and funding source • Using the child placement data, calculate the annual number of care days used. Calculate average daily unit cost by dividing total placement expenditures by care days used. Where possible, calculate the annual average daily unit cost by placement type.	MiSACWIS payment data; Quarterly WMPC PAFC Cost Reports; MiSACWIS placement data
How does the cost of out-of-home care in Kent County compare to the cost of out-of-home care in prior periods and to the rest of the state?		• The total of annual costs in Kent by service domain, category, and description to pay for the cost of services provided to children in out-of-home care and to their families to support the stable transition into a permanent home (Kent County costs will be limited here to those cost types that can also be accurately tracked outside of Kent County). • The total of annual costs in Michigan for a matched case comparison group of children by service domain, category, and description to pay for the cost of services delivered to children in out-of-home care and to their families to support stable transition into a permanent home. • The average annual daily unit cost of out-of-home placement in Kent County. • The average annual daily unit cost of out-of-home placement in the matched case group.	Using the costs for children served by the WMPC in Kent County and the costs for a matched case comparison group of children in the remainder of the state, compare the cost of out-of-home care by: 1. Comparing the proportion costs by expenditure categories for each group 2. Comparing the average daily unit cost of out-of-home care for each group 3. Comparing the growth rates by expenditure category in each group over time	MiSACWIS payment data; Quarterly WMPC PAFC Cost Reports; MiSACWIS placement data

Summary: Evaluation Plan				
Research Question	**Subquestions**	**Indicator**	**Method**	**Source**
Cost Study				
To what extent does the WMPC case rate (and subsequent capitated rate)[46] fully cover the cost of services required under the contract?		Difference between the total annual case/capitated rate revenue received and the total annual costs in Kent to pay for the full cost of services provided to children in out-of-home care and to their families to support a stable transition into a permanent home. Difference between the total annual contract WMPC administrative payment revenue received and the total annual WMPC administrative costs.	Examine and assess the extent to which total annual case/capitated rate revenue covered total annual applicable costs in Kent County. Examine and assess the extent to which total annual contract WMPC administrative payment revenue covered total annual applicable WMPC administrative costs. Examine and assess the extent to which case/capitated rates applied to individual child and family equals the total program and service expenditures for full case management and the services needed by the child and family.	MiSACWIS payment data; Quarterly WMPC PAFC Cost Reports
What are the cost implications of the outcomes observed under the transition to the Kent Model?		Cost-effective child and family outcomes	Cost sub-studies will be conducted for each successful outcome identified by the outcome evaluation. Details of these cost sub-studies will be dependent on the findings of the outcome evaluation. In general, examine and assess the type and costs of the services received by children referred for out-of-home services in Kent County compared to those service provided prior to the transition and to services provided concurrent with the transition to a matched cohort of children who have been served by a per diem private provider and who are receiving out-of-home services in all counties other than Kent County.	Outcome data and expenditures per case—MiSACWIS/ MiSACWIS payment data; Quarterly WMPC PAFC Cost Reports; MiSACWIS placement data

[46] In 2021, MDHHS' contract agreement with WMPC was revised to reflect the shift from a case rate to a capitated payment model (https://www.michigan.gov/documents/mdhhs/Section_5043_PA_166_of_2020_719406_7.pdf).

Summary: Evaluation Plan				
Research Question	**Subquestions**	**Indicator**	**Method**	**Source**
Outcome Study[47]				
Does the Kent Model improve the safety of children?		The children in foster care are safe from maltreatment experienced within an out-of-home setting	The number of children in each group with a CPS report occurring during a placement in foster care/out-of-home care (as determined by the report date or incident date when available) resulting in a CAT I, II, or III maltreatment disposition divided by the total number of children in each group, to be updated each reporting period.	MiSACWIS
		The children who experience a subsequent maltreatment event with a disposition of "preponderance of evidence" within 1 year of their previous report	The number of children in each group with a CPS report occurring within 1 year of their most recently substantiated (initial) report of maltreatment, to be updated each reporting period. This is limited to children with a foster care placement and associated with WMPC. This is not inclusive of all children in Kent County.	MiSACWIS
		The average length of time between maltreatment events for children experiencing maltreatment recurrence	The average length of time between maltreatment reports for children who were subjects of a CAT I, II, or III maltreatment disposition in the previous period and then have a subsequent CAT I, II, or III maltreatment disposition at • 3 months; • 6 months; and/or • 12 months.	MiSACWIS
		Risk of maltreatment recidivism	Examine the role that race, gender, age, history of maltreatment, and other important covariates play in explaining recurrence of maltreatment.	MiSACWIS

[47] Outcomes are measured by comparing WMPC-served children to a representative state sample (developed using propensity score matching).

Summary: Evaluation Plan				
Research Question	**Subquestions**	**Indicator**	**Method**	**Source**
Outcome Study[48]				
Does the Kent Model improve permanency for children?		The time children spend in foster care before exiting	The number of days children are in foster care prior to exiting to: • Reunification (physical and legal return) • Guardianship • Living with other relative • Adoption (physical and legal return).	MiSACWIS
		The children who enter foster care and who exit to permanency	The number of children who exit foster care to: • Reunification • Guardianship • Living with other relative • Adoption, divided by the number of children remaining in foster care.	MiSACWIS
		The children who are discharged from foster care and whose cases have been closed/remain open, and who re-enter foster care within 6, 12, or 18 months after case closure	The number of children who re-entered foster care within: • 6 months • 12 months • 18 months, divided by the number of children discharged from foster care.	MiSACWIS
		The children's risk of re-entry into foster care	Examine the role that race, gender, age, history of maltreatment, and other important covariates play in explaining the likelihood of achieving reunification and adoption.	MiSACWIS
		The children who experience two or more placement changes in a foster care episode	The proportion of children in foster care with two or more placement settings divided by the number of children in foster care.	MiSACWIS
		The children placed in each placement setting type during the current period	The proportion of children in the period in: • Family-based setting • Congregate-care setting	MiSACWIS

[48] Outcomes are measured by comparing WMPC-served children to a representative state sample (developed using propensity score matching).

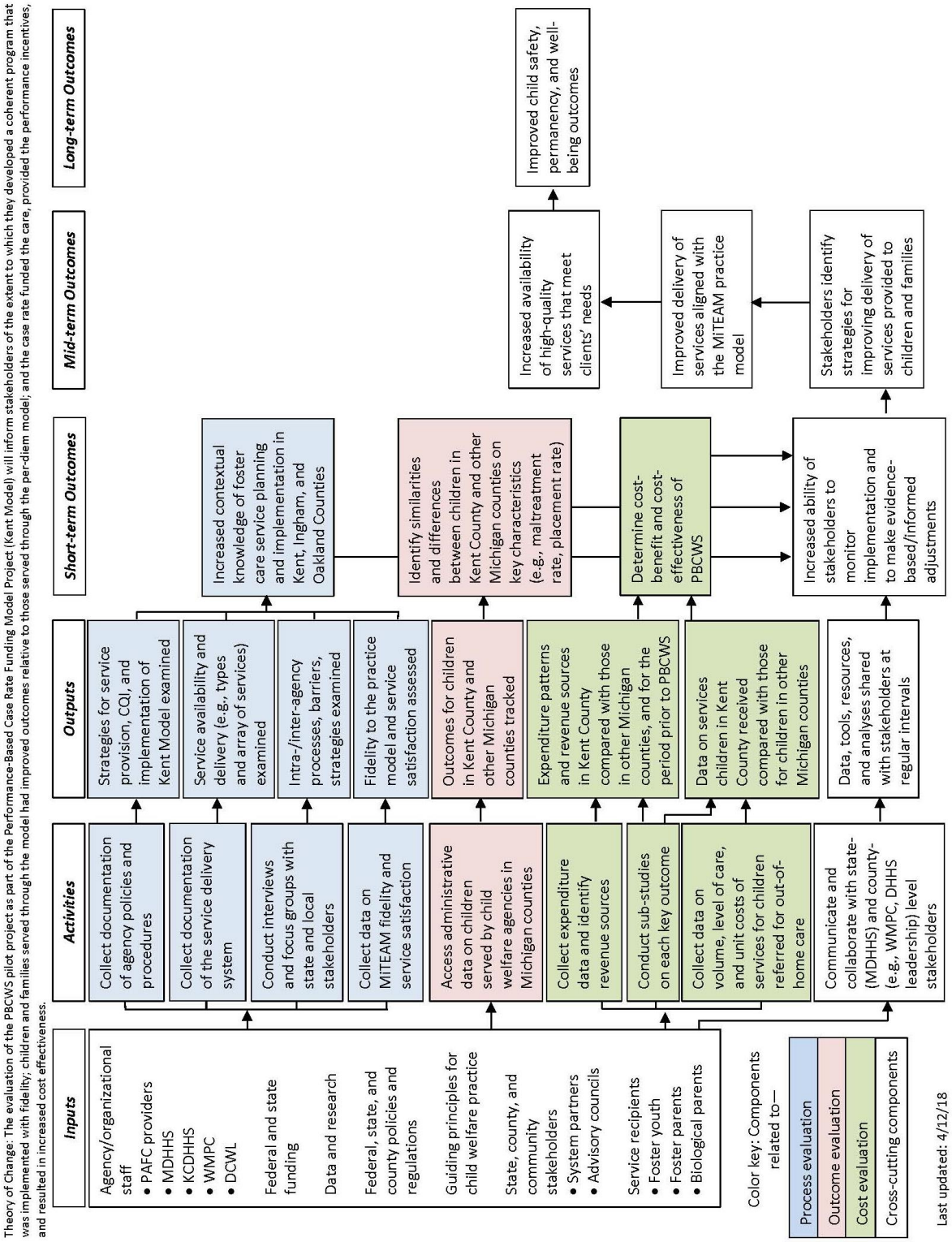
Summary: Evaluation Plan				
Research Question	**Subquestions**	**Indicator**	**Method**	**Source**
Outcome Study[49]				
Does the Kent Model improve permanency for children?		The placement setting changes over the length of stay in foster care	The proportion of children who experienced more than two placement setting changes by the number of months in foster care.	MiSACWIS
		For children in foster care with more than one placement setting, those who move to a less restrictive placement type, and those who move to a more restrictive placement type.	The number of children who move to a: • Less restrictive placement setting; or • More restrictive placement setting divided by the number of children in foster care placement.	MiSACWIS
		The youth who enter foster care as adolescents who experience permanent exits	The number adolescents in foster care who exit to: • Reunification • Guardianship • Relative Care • Adoption, divided by the number of adolescents remaining in foster care.	MiSACWIS
Does the Kent Model improve the well-being of children and families?		The children with an open case who receive timely physical/dental health care • Children in open cases receive timely and regular health exams • Children in open cases receive timely and regular dental exams	The number of children in open cases who receive timely and regular health exams divided by the number of children in open cases. The number of children in open cases who receive timely and regular dental exams divided by the number of children in open cases.	MiSACWIS
		The children entering foster care who receive timely physical/dental health care: • Children in foster care receive timely and regular health exams • Children in out-of-home care receive timely and regular dental exams	The number of children entering foster care who receive timely and regular health exams divided by the number of children in foster care. The number of children in out-of-home care who receive timely and regular health exams divided by the number of children in out-of-home care.	MiSACWIS

[49] Outcomes are measured by comparing WMPC-served children to a representative state sample (developed using propensity score matching).

Appendix C

Evaluation Logic Model

Appendix C
Evaluation Logic Model



Appendix D

Kent Expenditure Category Mapping

Appendix D
Kent Expenditure Category Mapping

Table D-1. FY15-FY17 – Kent expenditure categories

Service domain	Service category	Service description
Placement – Maint & Admin	CCI	0740- General Residential
Placement – Maint & Admin	CCI	0741-Mental Health and Behavior Stabilization
Placement – Maint & Admin	CCI	0742-Mother/Baby Residential Care
Placement – Maint & Admin	CCI	0744-Sexually Reactive Residential Care
Placement – Maint & Admin	CCI	0745-Shelter Residential Care
Placement – Maint & Admin	CCI	0746-Substance Abuse Treatment
Placement – Maint & Admin	CCI	0747-Short Term Residential
Placement – Maint & Admin	CCI	0748-Medium or High Security
Placement – Maint & Admin	CCI	0749-Boot Camp Residential Care
Placement – Maint & Admin	Detention – Paid	0762-State Detention – Paid
Placement – Maint & Admin	Foster Home	0700-Age-Appropriate Rate
Placement – Maint & Admin	Foster Home	0780-General Foster Care
Placement – Maint & Admin	Independent Living	0703-Independent Living Allowance
Placement – Maint & Admin	Independent Living	0782-General Independent Living
Placement – Maint & Admin	Independent Living	0783-Specialized Independent Living
Placement – Admin	Legislative Administrative Rate Increase	Legislative Administrative Rate Increase
Placement – Maint & Admin	MDHHS Training School – Paid	0763-MDHHS Training School – Paid
Placement – Maint & Admin	Treatment Foster Care	0788-Treatment Foster Care
Placement – Admin	Trial Reunification Payment	Trial Reunification Payment
Placement – Admin	BP515 – Admin Payment	BP515 – Admin Payment
FC Placement Service	Clothing	0801-Initial Clothing Allowance 0-5
FC Placement Service	Clothing	0802-Initial Clothing Allowance 6-12
FC Placement Service	Clothing	0803-Initial Clothing Allowance 13-21
FC Placement Service	Clothing	0804-Initial Clothing Ward Child
FC Placement Service	Clothing	0821-Special Clothing Allowance 0-5
FC Placement Service	Clothing	0822-Special Clothing Allowance 6-12
FC Placement Service	Clothing	0823-Special Clothing Allowance 13+
FC Placement Service	Clothing	0896-Semi Annual Clothing Allowance 0-12
FC Placement Service	Clothing	0897-Semi Annual Clothing Allowance 13+
FC Placement Service	Holiday Allowance	0898-Holiday Allowance
FC Placement Service	Transportation Support	0809-Parental Visitation Transportation
FC Placement Service	Transportation Support	0819- Sibling Visitation Transportation
FC Placement Service	Transportation Support	1809-Parental Visitation Transportation
Mental Health	Evaluation	0031-Psychiatric Evaluation
Mental Health	Evaluation	0034-Psychological Evaluation
Mental Health	Evaluation	0036 – Trauma Assessment (Comprehensive Team)
Mental Health	Evaluation	0037 – Trauma Assessment (Comprehensive Transdisciplinary)
Mental Health	Medical Charge Back	0882-Mental Health/Psyc. Expenses

Table D-1. FY15-FY17 – Kent expenditure categories (continued)		
Service domain	**Service category**	**Service description**
Residential Services	One on One Supervision	0834-One on One Supervision
Physical Health	Dental Expenses not covered by MA	0826-Dental/Orthodontics
Physical Health	Exam/Screening	0029-Child Sexual Abuse Exam
Physical Health	Medical Charge Back	0880-Medical Expenses
Physical Health	Medical Charge Back	0881-Dental/Orthodontic Expenses
Physical Health	Medical Expenses not covered by MA	0825-Medical Expenses
Physical Health	Other Medical	0001-Photocopies
Physical Health	Other Medical	0021-Other
Education	Educational Support	0805-School Tutoring
Education	Tuition	0831-Out of State School Tuition
Adult FC Service	Adult Foster Home	0837-Adult Foster Home
Independent Living Services	Daily Living	Computer Purchase/Software/Hardware
Independent Living Services	Graduation Expenses	0830-Class Ring
Independent Living Services	Housing	Rent/Security Deposit/Utility Deposit
Independent Living Services	Housing	Start-Up Goods
Independent Living Services	Transportation Support	0832-Driver's Education
Independent Living Services	Transportation Support	Vehicle Repair
Independent Living Services	Youth Development/Advocacy	Youth Board Meeting
Independent Living Services	Youth Development/Advocacy	Youth Communications Training

Table D-2. FY18-FY22 – Kent expenditure categories		
Service domain	**Service category**	**Service description**
Placement – Admin	CCI	PAFC Admin - WMPR_CR CCI
Placement – Maint	CCI	WMPC_CR CCI Placement Payment
Placement – Maint	Enhanced Foster Care	1787-Enhanced Foster Care
Placement – Maint	Enhanced Foster Care	1789-Enhanced Foster Care (step-down)
Placement – Maint	Foster Home	1780-General Foster Care
Placement – Admin	Foster Home	PAFC Admin - 1780 General Foster Care
Placement – Maint	Independent Living	1782-General Independent Living
Placement – Maint	Independent Living	1782-Independent Living-PAFC Supervised
Placement – Maint	Independent Living	1783-Specialized Independent Living
Placement – Admin	Independent Living	PAFC Admin - 1782 Independent Living
Placement – Admin	Independent Living	ILP Admin - 1783 Spec Independent Living
Placement – Maint & Admin	QRTP Child Caring Institution	751-Mental Health and Behavior Stabilization - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	771-JJ Mental Health and Behavior Stabilization - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	770-JJ General Residential - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	1754-Youth With Problematic Sexual Behaviors - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	1757-Specialized Developmental Disability - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	1751-Mental Health and Behavior Stabilization - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	1750-General Residential - QRTP
Placement – Maint & Admin	QRTP Child Caring Institution	1753-Developmentally Disabled/Cognitively Impaired - QRTP
Placement – Maint	Treatment Foster Care	1788-Treatment Foster Care
Placement – Admin	WMPC EFC Admin	WMPC EFC Admin
Placement – Admin	WMPC EFC Incentives	WMPC EFC Incentives
Residential Services	CCI	WMPC Other Purchased Services - Kids First
Residential Services	One on One Supervision	1834-One on One supervision
FC Placement Service	Assisted Care	1810-Assisted Care
FC Placement Service	Clothing	1801-Initial Clothing Allowance 0-5
FC Placement Service	Clothing	1802-Initial Clothing Allowance 6-12
FC Placement Service	Clothing	1803-Initial Clothing Allowance 13-21
FC Placement Service	Clothing	1821-Special Clothing Allowance 0-5
FC Placement Service	Clothing	1822-Special Clothing Allowance 6-12
FC Placement Service	Clothing	1823-Special Clothing Allowance 13+
FC Placement Service	Clothing	1824-Special Clothing Ward Child
FC Placement Service	Clothing	1896-Semi Annual Clothing Allowance 0-12
FC Placement Service	Clothing	1897-Semi Annual Clothing Allowance 13+
FC Placement Service	Holiday Allowance	1898-Holiday allowance
FC Placement Service	Transportation Support	1809-Parental Visitation Transportation
Mental Health	Clinical Counseling	Clinical Counseling
Mental Health	Evaluation	1031-Psychiatric Evaluation
Mental Health	Evaluation	1034-Psychological Evaluation
Mental Health	Evaluation	Neuropsychological Evaluation
Mental Health	Evaluation	Sex Offender Assessment
Mental Health	Group Counseling	Group Counseling

Table D-2. FY18-FY21 – Kent expenditure categories (continued)		
Service domain	**Service category**	**Service description**
Mental Health	Outreach Counseling	Outreach Counseling
Independent Living	Adult Education	Tutoring
Independent Living	College/Post Secondary Support	College application fees
Independent Living	College/Post Secondary Support	SAT/ACT preparation and testing
Independent Living	Conference/Camps/Workshops	Independent Living Skills
Independent Living	Daily Living	Computer purchase/software/hardware
Independent Living	Employment Support	Certification courses
Independent Living	Employment Support	Interview Clothing
Independent Living	Employment Support	License/certification fees
Independent Living	Graduation Expenses	1806-Senior Dues
Independent Living	Graduation Expenses	1806-Senior Expenses
Independent Living	Graduation Expenses	1830-Class Ring
Independent Living	Graduation Expenses	Senior Pictures
Independent Living	Housing	Rent/Security deposit/utility deposit
Independent Living	Housing	Start-up goods
Independent Living	Relationships	Healthy relationships
Independent Living	Secondary School Support	Educational Field Trip
Independent Living	Secondary School Support	Tutoring
Independent Living	Transportation Support	1832-Driver's Education
Independent Living	Transportation Support	Auto insurance
Independent Living	Transportation Support	Bus pass
Independent Living	Transportation Support	Driver's Education Classes
Independent Living	Transportation Support	Driver's Education Testing
Independent Living	Transportation Support	Gas card/reimbursement
Independent Living	Transportation Support	Other
Independent Living	Transportation Support	Vehicle purchase
Independent Living	Transportation Support	Vehicle repair
Independent Living	Youth Development/Advocacy	Youth board meeting
Physical Health	Dental Expenses not covered by MA	1826-Dental/Orthodontics
Physical Health	Medical Expenses not covered by MA	1825-Medical Expenses
Physical Health	Other Medical	1021-Other
Education	Educational Support	1805-School Tutoring
Education	School Age	Tutoring
Education	Tuition	1836-Summer School

Appendix E

Prospective Payment Recommendations

Appendix E
Prospective Payment Recommendations

When a state relies on a social sector agency to fulfill, in part, its child protection responsibilities, it enters into a contractual relationship with those social sector agencies. The contract defines who the agency is expected to serve and the services the agency is expected to deliver. The contract also specifies on what basis the agency will be reimbursed.

Historically, social sector agencies responsible for fulfilling a child protection mandate have been reimbursed using a fee-for-service mechanism. This is especially true in the case of foster care. The fee-for-service mechanism asks the provider to document that a service was provided for which the provider will receive an agreed upon fee. Hence, the fee-for-service idea.

Though fee-for-service reimbursement models work well in some cases, there are problematic aspects of paying for a provided service. First, administrative time must be devoted to determining whether a claim submitted is on behalf of an eligible client and eligible service. This is often a burdensome process for both state and social sector partners. Second, when providers are reimbursed for a service, there is a tendency to provide the services that yield revenue. Providers have a mix of fixed and variable costs to cover in the course of a Fiscal Year. The need to cover the costs puts upward pressure on service utilization. Last, when the state agencies that fund social sector services push agencies to be more effective with the services they deliver, the push may have adverse effects on the agency's revenue profile. The dynamic between revenue and agency performance is often characterized using the language of incentives. Fee-for-service reimbursement incentivizes utilization and disincentivizes program improvement. It is never that simple, but there is little doubt that the reimbursement mechanism affects service delivery choices.

As an alternative to fee-for-service reimbursement, there are a number of other ways to structure social sector reimbursement. Collectively, these alternatives are known as prospective payment models. Prospective payment models differ from fee-for-service arrangements in that reimbursement is tied more directly to the outcomes achieved rather than the services provided.

In Michigan, the WMPC pilot was a test of a prospective reimbursement model. Although the details are important, the main ingredients of the prospective model were put in place when the WMPC accepted a case rate as the basis for reimbursement. The case rate establishes an average rate of service utilization prospectively across the eligible population. The expected rate of utilization is tied to an average unit cost. The two together (expected utilization) and cost per unit provide the revenue projection the agencies need in order to know whether revenue will meet expenses. The WMPC case rate was replaced by a capped allocation, but the underlying model was largely unchanged. Capped allocations are merely another, different prospective payment model.

Viewed from afar, the WMPC pilot asked a simple question: When revenue is prospectively set, is the service provider able to alter the mix of services (regardless of whether the service is reimbursable under the old rules) so that children require less foster care? Under the foster care fee-for-service model, WMPC would have had to contend with a revenue shortfall that accompanies reduction in the utilization of foster care. Under the prospective payment model (case rate or capped allocation), WMPC retains the revenue in the prospective payment because payment is not contingent on a day of care being provided. Rather, the prospective payment is designed to cover

the expected utilization of foster care. If actual utilization is below the utilization built into the prospective model, the revenue is retained by WMPC. The revenue retained is the feature of the prospective payment model that undercuts the fee-for-service disincentives.

As a general matter, human service leaders are increasingly interested in prospective payment models. In health care, prospective payment for health-related services is a key component of the Affordable Care Act. Prospective payment models put flexibility and discretion in the hands of providers within a tighter accountability framework. Importantly, accountability is centered around outcomes rather than compliance-driven surveillance of agency operations. In short, prospective payment systems are on the leading edge of system change.

That said, the experience in Michigan with the WMPC pilot is instructive. The switch between case rates and capped allocations, together with the under- and overfunding of the pilot, show why it is important to place the prospective payment calculation on firm footing. In the early years, the case rate underfunded the pilot because the calculations used were not robust. There were other decisions made that affected the revenue shortfall, but none were more important than how the case rate was calculated. The switch to the capped allocation was similarly influenced by the choices made when deciding how much revenue WMPC should be awarded. In contrast to the case rate, the capped allocation projected revenue in excess of what was needed. Once again, the problem encountered was attributable to the calculation. Prospective payment models are a sound approach to reimbursement but the parameters of the payment model have to be realistic. In the case of WMPC, the case rate and the capped allocation parameters were unrealistic.

Looking forward, having accumulated experience with prospective payment methods, it would serve Michigan well if it expanded the use of prospective payment methods combined with a rigorous approach to outcome monitoring. The two go hand-in-hand and strengthen accountability by placing fiscal accountability on the same plane with outcome accountability. In the current fee-for-service system, the connection between fiscal accountability and outcome accountability is very weak to the extent it exists at all.

To succeed with expansion, the WMPC pilot offers lessons learned. First, the prospective payment calculation is important. Methods for doing robust prospective payment methods have been tested and applied with success in other jurisdictions. The WMPC fiscal evaluation used those methods and is one of the reasons the over- and under-allocation problems could be so clearly described.

Second, it is important to have a clear risk-sharing framework tied to the prospective payment model. Risk-sharing refers to what happens when revenue and expenditures fall out of alignment and for what reason. The early negotiations between WMPC and the DHHS serve as a useful example. When the revenue shortfall was identified, WMPC asked for additional revenue to cover the shortfall. Now, because of the over allocation of funds, DHHS and WMPC are negotiating how the surplus revenue will be expended, if at all. Both are examples of risk and risk sharing. By asking DHHS to cover the shortfall, WMPC asked DHHS to share the risk WMPC accepted when it agreed to the case rate as its prospectively established revenue. The gap between revenue and expenditures was the risk WMPC wanted to share with DHHS.

To strengthen risk sharing between the public agency and its social sector partners, it is important to break risk down into its components. In the case of WMPC and its foster care services, risk comes in three forms.

The risk that admissions to care will rise or fall to levels below the level used in the prospective payment model. This is what happened in the early years of WMPC. Admission changes were not addressed in the model. Admission changes are a risk for social sector agencies, so the risk-sharing plan has to be articulated.

Risk also comes in the form of length of stay. The prospective payment model has to project expected utilization measured as length of stay. If length of stay changes, how will this be handled. In a fee-for-service model, when length of stay goes down, revenue goes down. Program improvement induces this risk in a fee-for-service model. In the prospective payment model, the sharing of length of stay risks changes. How the risk will be managed is an important decision. Hold harmless provisions are used sometimes. Other times, leeway is built into the risk-sharing scheme so that the private agency understands the risk and the terms under which any shortfall may be passed back to the state.

Providers of service also face level of care risks. Level of care risks affect the unit cost parameter used in the prospective rate calculation. If admissions are steady and length of stay is unchanged but the level of care provided goes up, the prospective payment will not cover expenditures. Again, the specification of the unit cost risk and how it will be shared is important.

It is also important to remember that prospective payment models are not without their own, unique incentives. Whereas in the case of fee-for-service, there is a tendency to over serve, the incentives in a prospective payment model are in the under serve direction. In both cases it is important to closely monitor the level of service provided. We find the process, quality, capacity framework to be particularly helpful.[50] State policy and regulation generally defines the work that goes into providing care for children who are living away from home. This includes what workers are to do (e.g., visitation, reporting to the court) and caseload standards. Evidence-based practices are another source of process, quality, and capacity guidelines. To reiterate, incentives (or disincentives) cannot be side-stepped. Instead, the public agency has to put itself in the position of knowing when service quality is deteriorating and why.

Last, there are two additional reasons that expanding prospective payment models across the state represent a positive change for the system as a whole. In Tennessee, prospective payments were adopted as a strategy nearly 20 years ago when the state was in the midst of the Federal Brian A. lawsuit. Although the state of Tennessee used a long list of accomplishments to bring the lawsuit to a close, the prospective payment model together with closer monitoring of the social sector was an important element of the state's strategy.

Payment models also represent an important structural force within the system. To the extent there are disparities in the placement system, the fee-for-service model tends to reinforce how the foster care system is used. To back away from the current system and toward one that achieves greater equity in the distribution of resources, providers of service need greater flexibility. Prospective models provide a way to break through a structural barrier to change.

[50] https://fcda.chapinhall.org/wp-content/uploads/2012/10/2009_finding-the-return-on-investment.pdf